IN THE CHANCERY COURT FOR DAVIDSON COUNTY, TENNESSEE
TWENTIETH JUDICIAL DISTRICT

STATE OF TENNESSEE, ex rel. ANNE B. POPE,	)	
Petitioner,	)	
v.	)	No: 01-3206-III
TENNESSEE COORDINATED CARE NETWORK, MEDICAL CARE MANAGEMENT COMPANY, ACCESS HEALTH SYSTEMS, INC.,	)	
Respondents,	)	

REPORT OF THE SPECIAL DEPUTY LIQUIDATOR

By order of the court filed March 28, 2002, Howard H. Vogel, was appointed to proceed as Special Deputy Liquidator (SDL), pursuant to the provisions of T.C.A. §56-9-310(a)(1), to evaluate the following matters in litigation, which were pending at the time of the liquidation:

(a) **TCCN v. State of Tennessee**, Davidson County Chancery Court, Case No. 01-1791-II;

(b) **TCCN v. Neel, et al,** United States District Court for the Middle District of Tennessee, Case No. 3:00-1226; and

(c) **TCCN v. Neel, et al,** United States District Court for the Middle District of Tennessee, Case No. 3:01-0126.

The initial order provided that the report of the SDL was to be filed no later than August 1, 2002. Subsequently, on petition for the benefit of the SDL, the Court extended the time for reporting to September 16, 2002.

From the time of appointment until the issuance of this report, the SDL has reviewed various documentation, listed in Exhibit A hereto. In general, this documentation included various pleadings from the subject suits, various depositions from other TennCare matters, various health policy reports, State of Tennessee audit and review information and various legal authorities, including but not limited to citations relied upon by the parties in the subject suits. The SDL met with Paula Flowers, counsel for the Liquidator and who assisted the SDL in arranging for informational meetings and production of various documents. The SDL met with

Kevin Steiling, Steve Hart and Linda Ross of the Attorney General's Office on March 22, 2002, to discuss the background and status of the Pending Litigation. The SDL met with Irwin Venick on April 11, 2002 to discuss the Pending Litigation. The SDL participated in a conference call on June 7, 2002, with various representatives of the healthcare providers to solicit their input into appropriate areas of inquiry, focus and analysis by and for the SDL. There have been relatively brief telephone conversations with John Murdock and Jim Kelly.

The vast majority of the effort was devoted to a review of the pleadings and related documents.

The purpose of this report is to set out for consideration by this Honorable Court, the findings, conclusions and recommendations of the SDL regarding the profitability of the subject suits. To establish the basis for these opinions and recommendations, the SDL offers the following discussion and review of the three subject proceedings, TCCN and relevant history regarding the TennCare Program:

Some Background on TCCN

Tennessee Managed Care Network was incorporated as a not-or-profit corporation on July 11, 1983. It was originally named the Tennessee Association of Primary Health Care Centers, Inc. It was funded through grants from the Robert Woods Johnson Foundation of Princeton, New Jersey, The Lyndhurst Foundation of Chattanooga, Tennessee, and the Commonwealth Fund of New York, New York. It began operation as a health insuring organization upon entering into a contract with the Tennessee Department of Health and Environment. Under the terms of that contract, it was to coordinate the delivery of certain health services for eligible recipients of the Aid to Families with Dependent Children (AFDC) portion of the Tennessee Medicaid program, as authorized under Title XIX of the Social Security Act. This "MedPlus" line of business generated most of the Company's revenue until its entry in the TennCare Program.

It had two other programs that provided health insurance benefits to uninsured businesses in Shelby County. These were known as MedTrust and Access. After entering the TennCare Program, these two accounted for less than one percent of the Company's revenues.

On July 31, 1987, the Company assumed all provider contracts, subscriber agreements and operational liabilities of the Tennessee Health Plan (THP). TMCN previously performed services for THP under a management agreement, executed with THP in September of 1984.

TMCN received its certificate of authority to provide services as an HMO from the State of Tennessee on May 6, 1988. On February 6, 1992, it changed its name to Tennessee Managed Care Network. It entered into a Contractor Risk Agreement with the State of Tennessee on January 1, 1994, to participate as part of the TennCare Program. See Examination Report of TCMN as of August 31, 1995.

The SDL has prepared a timeline that is attached as Exhibit B.

A. TCCN v. State of Tennessee

Davidson County Chancery Court,
Case No. 01-1791-II

Claim for Damages before the Claims Commission - This suit was filed in the Claims Commission of the State of Tennessee as a claim for damages on December 12, 2000. The claims sought recovery of an amount estimated to be at least one hundred, sixty million dollars ($160,000,000.00) for breach of an express contract between the parties. The claim provided that in the event of an award, TCCN intended to retain no more than fifteen percent (15%) and to distribute the balance to health care providers, who provided TennCare covered benefits to its members during the period covered by the award. It was alleged that the State of Tennessee failed to calculate and pay capitation rates to the Tennessee Coordinated Care Network in an actuarially sound manner, as required by the Contractor Risk Agreement between the parties. The claim contended that the capitation rates paid to the plaintiff for the period of December 1, 1994, through the date of the claim, were not actuarially sound in violation of the Federal Medicaid Act, the TennCare Waiver and the TennCare Contractor Risk Agreement between the State of Tennessee and the claimant. The claims sought the calculation of an actuarially sound capitation rate for the years 1994, 1995, 1996, 1997, 1998, 1999 and 2000. The claim requested that the State of Tennessee pay TCCN based upon a actuarially sound capitation rate for those years and through the date of any final adjudication of the claim.

The claim recounted the history of TennCare, as a program authorized by the Tennessee Legislature. TennCare resulted from an amendment of the Tennessee Medical Assistance Act,

effective January 1, 1994, to provide that medical assistance could be provided pursuant to any federal waiver received by the State that waived any or all of the provisions of Title XIX, the Federal Medicaid Act. By letter of June 16, 1993, the State of Tennessee requested that the Health Care Financing Administration (HCFA) of the United States Department of Health and Human Services (HHS) approve TennCare as a Medicaid demonstration project pursuant to Section 1115(b) of the Social Security Act. This section permits HHS to waive certain federal Medicaid requirements that would otherwise apply to a Medicaid funded program. By letter of November 18, 1993, HHS informed the State of Tennessee that TennCare had been approved as a Medicaid demonstration project and that certain provisions of federal law were waived. Thirty-five (35) special terms and conditions were set for compliance by the State of Tennessee. TCCN contended that among the requirements of the Medicaid Act that remained in effect was the requirement that capitation rates paid to a managed care organization (MCO) be calculated in an actuarially sound manner. 42 U.S.C. §1396b(m)(2)(A)(iii); 42 C.F.R. §434.61. Further, TCCN contends that another Medicaid Act requirement remain in effect requiring that payments must be consistent with efficiency, economy and quality of care and sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area. 42 U.S.C. §1396a(a)(30)(A); 42 C.F.R. §447.204.

TCCN contends that when TennCare was created in 1993, the State of Tennessee turned to TCCN, which was the only licensed health maintenance organization (HMO) in Tennessee with any experience providing manage care services to the Medicaid eligible population, in order to implement the TennCare program. BlueCross/BlueShield of Tennessee and TCCN were specifically referenced in the TennCare application for a waiver. TCCN entered into a contractor risk original agreement with the State of Tennessee on November 29, 1993. The original agreement provided that TCCN was to receive a monthly payment for each TennCare eligible person assigned to TCCN. TCCN contends that that rate was not calculated in an actuarially sound manner, as required by the Federal Medicaid Act and the contract between the parties. TCCN alleges that the capitation rate was knowingly set below that which would have been established on an actuarially sound basis, in order to hedge against the unknown cost of the TennCare program.

TCCN executed a revised contractor risk agreement in September of 1995. TCCN contends that the amended agreement contains several onerous new provisions that were not subject to negotiation. TCCN contends that it was advised that if it did not sign the amended agreement, it would not be eligible to receive a 4.5% increase in its capitation rate and an additional 4.5% increase in the capitation rate to be paid in the future. TCCN then signed the agreement, because it believed that the existing rate was not calculated in an actuarially sound manner and was insufficient to cover the costs of the TennCare services which TCCN was obligated to arrange. TCCN contends that the subsequent amended agreements were signed, utilizing respective capitation rate increases to require TCCN and other HMO's to sign. They were onerous and one sided.

In March of 1999, Price Waterhouse Coopers (PWC) issued a report regarding the actuarial soundness of the capitation rate paid under the TennCare program. The study was commissioned by the office of the Comptroller of the State of Tennessee. It concluded that the methods used for calculating the capitation rate were not consistent with generally accepted standards; (2) corrections to the capitation rate methodology would result in increases in capitation rates ranging from 5% to 35%, with a best estimate of 20%; (3) providers were being paid at a rate that was significantly below the cost of providing TennCare services; (4) adverse selection should be calculated as a part of the capitation rate; (5) manage care organizations were being paid at a rate that was at least sixteen dollars ($16.00) per patient/per month lower than the amount that would be considered actuarially sound; (6) cost shifting from TennCare to other purchasers was occurring because of the below market payment rates being paid to providers, and (7) the current funding levels could not be sustained while insuring adequate access to care.

TCCN contends that on or about May 10, 1999, Brian Lapps, Jr., then Director of the Bureau of TennCare, acknowledged to the TennCare Oversight Committee of the Tennessee General Assembly that the Bureau of TennCare concurred with the conclusions of the PWC capitation study. In April of 2000, PWC issued a second report, commissioned by the Tennessee Office of the Comptroller, to develop per capita costs for the TennCare program for fiscal year 2001. PWC described what it referred to as an actuarially sound capitation rate methodology for fiscal year 2001. PWC proposed a change in the capitation rate to be paid to TCCN, as well as the other TennCare HMO's. TCCN contends that the methodology developed in the April 2000

TennCare capitation study is not actuarially sound, and that the capitation rate being paid to TCCN, based upon that study is not an actuarially sound capitation rate.

TCCN contends that by failing to calculate the capitation rate paid to it in an actuarially sound manner, the State of Tennessee has breached both the original agreement and the amended agreement. TCCN contends that this has resulted in damage to it. It contends that the State of Tennessee has acted arbitrarily, capriciously, and not in good faith as required by the original and subsequent agreements.

TCCN requested a declaration that the State of Tennessee had breached both the original agreement and the amended agreement by paying a capitation rate not calculated in an actuarially sound manner. It requested an award in an amount to be determined by the Claims Commission to be the difference between what was paid and what should have been paid, but in an amount not to exceed one hundred, sixty million dollars ($160,000,000.00).

This claim was removed to the Chancery Court for Davidson County, Tennessee and is now cause no. 01-1791-II.

B. TCCN v. Neel et al

United States District Court for the Middle District of Tennessee,
Cause No. 3:00-1226

Complaint and First Amended Complaint - This suit was filed in the United States District Court for the Middle District of Tennessee on December 13, 2000 as cause no. 3:00-1226. Tennessee Coordinated Care Network sued Warren Neel, in his official capacity as Commissioner of the Tennessee Department of Finance and Administration, for the State of Tennessee; Mark Reynolds in his official capacity as Director of the Bureau of TennCare; and Frieda Wadley, M.D., in her official capacity as Commissioner for the Tennessee Department of Health. The suit was brought for declaratory and equitable relief pursuant to 42 U.S.C. §1983.

TCCN requested that the Court declare that the capitation rates being paid to it and other TennCare manage care organizations for the period as of the date of the filing of the complaint are not actuarially sound in violation of the Federal Medicaid Act. It also requested an injunction upon the defendants to determine actuarially sound capitation rates for the fiscal year 2000 and thereafter and to order that the defendants submit to the court for approval actuarially sound capitation rates for the year 2000 and thereafter, and for a plan for the payment of any

additional capitation payments to plaintiff, as well as reasonable attorney fees, expenses and costs.

In its description of the parties, TCCN identified Warren Neel as the duly appointed and qualified Commissioner of the Department of Finance and Administration for the State of Tennessee. One of his duties is to administer and oversee the TennCare health benefits program for the State of Tennessee. Mark Reynolds was identified as the duly appointed and qualified Director of the Bureau of TennCare. His duty is to direct the operations of the TennCare Health Benefits Program for the State of Tennessee. Frieda Wadley, M.D., was identified as the duly appointed and qualified Commissioner for the Department of Health for the State of Tennessee. Her agency is designated and responsible, as required by the Federal Medicaid Act, for the operation of the Federal Medicaid Program in the State of Tennessee.

In its complaint, TCCN recites the background for the development and creation of TennCare, as contained within its claim filed with the Claims Commission. TCCN cites the Medicaid Act requirement that it says remained in effect, notwithstanding the waiver obtained for the TennCare program and requiring that the capitation rate paid to manage care organizations, such as it, be calculated in an actuarially sound manner. 42 U.S.C. §1396a(a)(30)(A); 42 C.F.R. §447.204. TCCN recounted the same contracting amendment scenario, along with the Price Waterhouse Coopers capitation rate study issued in March of 1999. TCCN included the references to the April, 2000, PWC report.

In this case, TCCN sought a declaration by the Court that the defendants had deprived TCCN of rights secured under federal law because the capitation rights paid to TCCN had not been and were not actuarially sound. The plaintiff requested that the Court order the defendant Neel and Reynolds to submit to the court, for its approval, actuarially sound capitation rates for the year 2000 and any subsequent year through the date of judgment, along with a plan for the payment of any additional capitation payments to TCCN. Reasonable costs and attorney fees were also requested.

TCCN filed an amended complaint, proceeding only against the defendants Neel and Reynolds in their official capacities. The amended complaint substantially incorporates the allegations of the original complaint and adds some explanation regarding the requirements of the Medicaid Act and associated regulations. The amended complaint also restates one of the findings of Price Waterhouse Coopers in the March 1999 report to state that manage care

organizations were being paid at rates that were at least eleven dollars ($11.00) per patient/per month lower than the amount that would be considered actuarially sound.

In its prayers for relief, TCCN requested that the Court declare that the defendants had deprived TCCN of rights secured under federal law because the capitation rates paid to plaintiff were not actuarially sound in violation of 42 U.S.C §1396b(m)(2)(A)(iii), 42 C.F.R. §434.23(a), 42 C.F.R. §434.61 and 42 U.S.C. §1396a(a)(30)(A). TCCN requested that the Court enjoin the defendants to calculate capitation rates for the TennCare waiver program, which are actuarially sound as required by the Federal Medicaid Act and order the defendants to submit to the Court for approval, actuarially sound capitation rates to be effective after the date of judgment. TCCN also requested reasonable costs and attorney's fees.

C. Tennessee Coordinated Care Network, Inc. v. Warren Neel, Commissioner Tennessee Department of Finance and Administration, John F. Tighe, Deputy Commissioner Tennessee Department of Finance and Administration, Ann B. Pope, Commissioner Tennessee Department of Commerce and Insurance, Manny Martins, Deputy Commissioner Department of Commerce and Insurance

United States District Court for the Middle District of Tennessee, Cause No. 3:01-0126

Verified Complaint for Declaratory Judgment, Preliminary and Permanent Injunction Relief - This suit was originally filed in the Chancery Court for Davidson County, Tennessee as Case No. 01-12-I. It was removed to the United States District Court for the Middle District of Tennessee. The suit was originally filed on January 3, 2001.

In this suit, TCCN seeks a declaratory judgment that the defendants, acting in their official capacities, are violating the federal and state laws governing the operation of the Tennessee Medicaid Program called TennCare and that the civil rights of TCCN, protected under federal and state law. TCCN sought a preliminary and permanent injunction against the defendants continuing violation of those laws and rights.

TCCN averred that it is a not-for-profit health maintenance organization incorporated in the State of Tennessee with its principal place of business in Nashville, Tennessee. It averred that it is an African-American managed and operated entity and is recognized as a minority business enterprise within the meaning and for the purpose of the statues, laws and regulations contained within the complaint. It alleged that it had a managed care risk contract with the State through the Tennessee Department of Finance and Administration Bureau of TennCare to

provide services to Medicaid beneficiaries enrolled in the TennCare program who select TCCN as their Medicaid managed care provider.

The defendant Warren Neel is identified as the Commissioner of the Tennessee Department of Finance and Administration with the authority for the administration of one of the two state agencies through which TennCare is administered and responsible for the implementation and enforcement of the Tennessee Medical Assistance Act of 1968. The defendant John Tighe is identified as the Deputy Commissioner of the Department of Finance and Administration, Bureau of TennCare, with the responsibility for the administration of TennCare and for implementing and enforcing the Tennessee Medical Assistance Act of 1968. The defendant Ann B. Pope is identified as the Commissioner of the Department of Commerce and Insurance with the responsibility for the other one of the two state agencies through which TennCare is administered and is responsible for the implementation and enforcement of the State's Insurance Code and the State's HMO Act which are part of the Tennessee laws governing TennCare. The defendant Manny Martins is identified as the Deputy Commissioner of the Department of Commerce and Insurance, TennCare Division, with the responsibility for the oversight of the MCO's in TennCare and responsibility for implementing and enforcing the Tennessee Insurance Code and HMO Act, which are part of the state's laws governing TennCare.

TCCN avers that the TennCare defendants are obligated to administer TennCare in compliance with the Medicaid Act and federal civil rights laws. It is averred that the TennCare defendants have acted in gross dereliction of their obligations by violating 42 U.S.C. §1981 *et seq.* and 42 U.S.C §2000d *et seq*. by changing the methodology for setting MCO reimbursement rates in order to materially reduce TennCare payments to TCCN, an African-American owned or managed MCO in TennCare so that the insurance department defendants could deem or attempt to deem TCCN financially unqualified to continue to participate in TennCare. TCCN further avers that the TennCare defendants violated 42 U.S.C. §1981 *et seq.* and 42 U.S.C. §2000d *et seq.* by intentionally increasing enrollment of adverse risk Medicaid beneficiaries to TCCN in order to increase financial liabilities and render it financially unsound and provide more favorable financial conditions for the white owned or operated MCO's in the TennCare program. TCCN also avers violation of theses statutes by repeatedly using pretextual reasons and threats to compel TCCN to submit to succession of regulatory examinations, supervisions and

rehabilitation, when the true reason for these actions is to remove TCCN from TennCare because TCCN is an African-American owned or managed MCO. TCCN alleges that the defendants violated 42 U.S.C. §1396(a) by setting the MCO reimbursement rates so low that this is a marked disparity between Medicaid beneficiary access to health care providers in TennCare and non-medicaid individuals access to health care providers because MCO providers either will not, or cannot, continue to participate in TennCar e at such low reimbursement rates.

As background, TCCN avers that TennCare must allow any qualified MCO to have a contract. Qualification means meeting certain criteria specified in the contract and the state HMO Act. These include financial solvency and prompt payment of physician claims for payment for services. Medicaid beneficiaries either select or sign to an MCO in TennCare and must obtain all of their covered services from or by referral from a primary care physician or gatekeeper who has contracted with the MCO to participate in the MCO's network of providers. The MCO is reimbursed on a monthly per capita fee for each beneficiary enrolled. This covers all cost of care that the MCO is obligated to provide. The MCO may retain as profit the net positive difference between what it receives and its costs. The risk in the contract is the potential that the expense will exceed the amount received. This is the risk of the MCO.

At the end of 1998, TCCN avers that approximately eighty percent (80%) of the State's more than 1.3 million Medicaid beneficiaries were enrolled in one of three of the nine MCO's that had contracts with TennCare. BlueCross/BlueShield had approximately forty-five percent (45%) of the total. TCCN had approximately twenty percent (20%). Xantus Healthplans had approximately fifteen percent (15%) of the total. BCCS is white owned or managed. TCCN and Xantus are or were African-American owned or managed.

TCCN alleges that TennCare has been mismanaged and grossly underfunded for most of its existence since 1994. In 1998, 1999 and continuing into 2000, TCCN alleges that the TennCare defendants have engaged in a serious of venal actions targeting TCCN as an African-American MCO with the intent to impair its financial ability to comply with state laws, to interrupt its business operations, to damage its business reputations and ultimately to render it not qualified to hold a TennCare contract. TCCN alleges that none of the non-African-American MCO's have been subjected to such actions or been the victims of the disparate impact of those actions.

TCCN avers that prior to July of 2000, TennCare was contractually obligated to make a supplemental payment to each MCO each month for each person identified as having a "high cost chronic condition" whom the MCO actually served during that month. This payment is referred to in the contract as compensation for "adverse selection." Adverse selection refers to those Medicaid beneficiaries for whom the cost to deliver care is more expensive than the cost to deliver care to the average Medicaid beneficiary. TennCare develops the per capita adverse selection rate without consultation or negotiation with the MCOs. It is alleged that TCCN has and continues to have at the time of the filing of the complaint, a disproportionate number of adverse selection enrollees and the highest percentage number of adverse selection enrollees of all the MCO's in TennCare.

It is alleged that in 1995, the TennCare defendants alleged that TCCN had failed to meet minimum statutory net worth requirements. On December 28, 1995, the TennCare defendants demanded that TCCN make a capital infusion of five million, five hundred, eighty-eight thousand, one hundred, fifty dollars and ten cents ($1,588,150.10) within twenty days (20) to ensure its financial viability. At that time, it had on its books a receivable from the State of Tennessee which totaled approximately twenty-one million ($21,000,000.00). The TennCare defendants disputed the receivable and disallowed it in calculating TCCN's statutory net worth. TCCN raised the necessary capital to meet the purported financial requirements of the TennCare defendants pursuant to an arrangement wherein it sold all of its fixed assets to Medical Care Management Company (MCMC) for an amount sufficient to meet the purported shortfall. A subsequent examination report of TCCN's net worth by the TennCare defendants for the period of September 1, 1995 to March 31, 1996 revealed that TCCN had a net worth that was approximately eight million dollars ($8,000,000) above the minimum net worth required by the State under the TennCare contractor risk agreement or state law.

TCCN alleges that in the fall of 1998, the finance department defendants retroactively implemented a new methodology for establishing the adverse selection payments for the period beginning July 1997 and continuing through the time of the filing of the complaint. The new methodology reduced the adverse selection payments to TCCN by approximately fifty percent (50%) and had the effect of discrimination against TCCN, because of the disproportional high percentage of adverse selections of enrollees. Xantus was also adversely impacted by the new methodology. The retroactive dollar impact on TCCN was a loss of seventeen million dollars

($17,000,000.00) for 1998. In the spring of 1999, TennCare distributed to all MCOs a retroactive two percent (2%) increase in capitation rate for the period of July 1998 to June 1999. A condition for receipt of the funds was the signing of an agreement prohibiting the MCO's from using the increased funding to pay management fees and waiving all of the MCO's right to challenge TennCare's adverse selection payment history and retroactively imposed methodology. This condition for receipt of the retroactive capitation increase was directed at TCCN and other African-American owned or operated MCOs which were the only MCOs materially impacted by the restrictions on the use of retroactive capitation, retroactive adverse selection adjustment, and whose relinquishment, under duress, of a right to challenge the adverse selection adjustment had any financial significance according to TCCN.

TCCN alleges that it and Xantus were the only MCOs with management fees. The retroactive seventeen million dollar adverse selection action against TCCN caused it to suffer a deficiency in its statutory net worth. By state law, all HMOs are required to maintain a certain financial net worth, based upon the number of persons enrolled. For TCCN, this was approximately ten million dollars ($10,000,000.00) in 1999. The retroactive seventeen million dollars ($17,000,000.00) adverse selection action against TCCN impaired its ability to meet its contractual reimbursement obligations to its network providers. It contends that but for this retroactive seventeen million dollar adverse selection action, it would have met its ten million dollar statutory net worth requirement and would not have experienced any problems meeting its obligations to make prompt payments to providers during that time.

In July of 1999, TCCN submitted a plan to the insurance department defendants to correct the statutory net worth deficiency. The plan required TCCN to utilize the two percent (2%) retroactive increase capitation payment it had received and an additional sixteen dollar ($16.00) per member/per month increase in the capitation rate the Legislature had authorized the finance department defendants to pay to the MCOs. The insurance department defendants admitted that they would approve the action plan of TCCN, if the finance department defendants decided to make the twelve dollar, forty cent ($12.40) plan payments, authorized by the Legislature. In August of 1999, the finance department defendants announced their decision to make the twelve dollar, forty cent ($12.40) plan payments and the insurance department defendants revoked their prior commitment to approve the action plan of TCCN to correct the statutory net worth deficiency. It is alleged that the insurance department defendants refused to

give any reason for their refusal to allow TCCN to allocate to its corrective action plan, the capitation payments paid to it retroactively and the twelve dollar, forty cent ($12.40) plan payments authorized by the finance department defendants, which would in any other circumstances have counted toward net worth. TCCN was instructed in writing and verbally that it would have to comply with certain restrictions upon its use of the twelve dollar, forty cent ($12.40) plan dollars being distributed. Those restricted criteria were not applied to all of the other MCOs. The insurance department defendants did not approve a corrective action plan for TCCN until December of 1999. In the interim, TCCN was able to demonstrate by November of 1999 that it had met and exceeded its statutory net worth obligations.

TCCN alleges that in addition to the obvious attempt to financially destabilize TCCN through the adverse selection adjustment and restrictions on the use of the twelve dollar, forty cent ($12.40) plan dollars, the TennCare defendants disallowed use by TCCN of seven hundred, seventy thousand dollars ($770,000.00) paid by TennCare to TCCN for high cost pregnancies to calculate statutory minimum net worth; paid TCCN only fifty percent (50%) of the amount that it owed TCCN for high cost pregnancies; and barred TCCN from advertising to TennCare members.

It is alleged that in December of 1999, TCCN began a full conversion of its computer information system, which also include the claims system for paying network providers' claims. Under the new system, claim payments to physicians were slower than normal. This was reported to the insurance department defendants. TCCN informed them that it was making advance payments to physicians to offset the negative effect of the slower claims payment process through the system conversion. The Peterson Group, a consulting company, issued a review in January 2000 of the TCCN processing of physician claims and compliance with the prompt payment requirements. The Peterson Group concluded that TCCN was processing claims in accordance with the TennCare contract and state law requirements and that TCCN had an appropriate strategy for fixing the problems being encountered with the information system conversion. The insurance department defendants sent another consulting company, Mercer Company, to TCCN to review the new information system and TCCN's claims payments in late January of 2000. On the evening preceding a scheduled meeting between the insurance department defendants, TCCN and Mercer, to discuss the purpose and protocol for the review, the insurance department defendants faxed a request for data and documentary reports to TCCN

for production and availability for the meeting, scheduled for the next day. This time frame was unreasonable and demonstrated an intention to set up TCCN to be unable to have the data and reports in time for the meeting.

The meeting occurred and thereafter Mercer generated a report in which it included that although the information system had problems, TCCN's strategy for resolving the problems was appropriate. The insurance department defendants began soliciting written statements for accounts receivables from TCCN network providers for the period 1998, 1999 and 2000. A second Mercer review was initiated without an basis and fact and for the sole purpose of establishing pretextual grounds for further regulatory action and discrimination against and depravation of rights of TCCN. This Mercer report concluded that the TCCN informatio n system was not capable of being adjusted to resolve the claims payment difficulties.

TCCN alleges that on June 14, 1999, the insurance department defendants compelled TCCN either to enter into an agreed order of restrictive regulatory oversight or ris k suspension or revocation of its certificate of authority to operate as an HMO. The pretext was the failure of TCCN to meets it statutory minimum net worth requirement, even though the alleged failure was due entirely to TennCare's retroactive seventeen million dollar reduction of TCCN's adverse selection payments. On August 6, 1999, the insurance department defendants issued a directive prohibiting TCCN from using the retroactive capitation rate increase to address the net worth deficiency. On August 25, 1999, the insurance department defendants requested TCCN to provide information about Access Health Systems, an entity unrelated to TCCN, no later than August 26, 1999. On September 9, 1999, insurance department defendants compelled TCCN to either agree to an extension of the June 14, 1999 order of restrictive regulatory oversight or risk suspension or revocation of its certificate of authority to operate as an HMO.

On November 9, 1999, the insurance department defendants again compelled TCCN either to agree to an extension of the June 14, 1999 order of restrictive regulatory oversight or risk suspension or revocation of its certificate of authority to operate as an HMO. On January 21, 2000, the insurance department defendants issued a subpoena for senior officials of TCCN and Access Health Systems to produce documents about the operation of two unaffiliated companies. On February 3, 2000, the insurance department defendants compelled TCCN to enter into a letter agreement to allow the insurance depar tment defendants to continue to examine TCCN. In March of 2000, TCCN declined to consent to an agreed order of restrictive regulatory

oversight and was informed by the TennCare defendants that its March capitation payment would not be paid in accordance with normal practices. On March 6, 2000, TCCN executed a "letter of examination" with the insurance department defendants and the finance department defendants released the March capitation payment to TCCN.

In late March and early April of 2000, the TennCare defendants informed State Legislature leaders that TCCN would be placed in rehabilitation soon. In June of 2000, TennCare compelled TCCN to enter into another supervision. In September of 2000, TennCare compelled TCCN to enter into an extension of the June 2000 supervision to continue through June of 2001. In the fall of 2000, TCCN again demonstrated it met statutory net worth requirements. In November of 2000, TCCN filed a petition under the Tennessee statute challenging various actions by the insurance department defendants as *ultra vires*. TCCN alleges that in December of 2000, TennCare defendants provided false and misleading data to State legislators about the financial conditions of TennCare MCOs, including TCCN. On December 7, 2000, the TennCare defendants provided false and misleading data to State legislators about TCCN and publicly stated that TCCN's financial records are not credible. TCCN alleges that as recently as December of 2000, the TennCare defendants have informed legislators and other persons that TCCN is going to be placed in rehabilitation.

On December 11, 2000, TCCN filed its action with the Claims Commission, challenging the lack of proper funding of TCCN and a federal court action on December 13, 2000, requiring the TennCare defendants to set actuarially sound rates for TennCare. In December of 2000, the insurance department defendants more aggressively encouraged TCCN providers to challenge recoupment of overpayments by TCCN caused by a faulty computer system and interfered with a contractual relationship of TCCN with its providers, all in an effort to undermine its relationships and unsettle its network of providers with negative impact on the net worth of TCCN. On December 21, 2000, the TennCare defendants demanded that TCCN execute a consent order of statutory rehabilitation no later than January 2, 2001. A hearing on the petition filed by TCCN against the Department of Insurance was expected to be heard sometime in January of 2001.

TCCN alleges that the TennCare defendants have unlawfully manipulated the process by which Medicaid beneficiaries are enrolled in MCOs, in order to divert a significant percentage of the adverse selection population to TCCN. It is alleged that the defendants have done so in an

order to shift the effect of adverse selection and this increased TCCN's financial risk and made it more difficult for TCCN to meet statutory net worth requirements.

TCCN alleges that as a healthcare provider it is an intended beneficiary of the equal access clause under 42 U.S.C. §1396a and may enforce it under 42 U.S.C. §1983 *et seq*. It contends that the Equal Access Clause obligates the TennCare defendants to establish Medicaid provider reimbursement rates at adequate levels to enlist enough providers, including MCOs to participate in TennCare so that Medicaid enrollees have access to care equivalent to the general population of non-Medicaid enrollees. TCCN alleges that the TennCare defendants must comply with the Equal Access Clause within the context of the TennCare program, which is open to any qualified MCO. All MCO's received the same contract and are paid the same capitation rates with risk for excess cost. It is alleged that the TennCare defendants have violated the Equal Access Clause by providing less medical care to Medicaid recipients than the medical care enjoyed by the general population. Further, it is alleged that the TennCare defendants have violated the clause by establishing reimbursement rates that are inefficient, uneconomical, undermined quality of care and inhibit the development and maintenance of adequate numbers of providers. TCCN contends that this is proven by the financial collapse of Xantus, which had fifteen percent (15%) of the TennCare enrollees. It is further established by the departure from TennCare of BlueCross/BlueShield as an at risk contractor for approximately forty-five percent (45%) of the TennCare enrollees and further by the potential disqualification of TCCN, which had approximately twenty percent (20%) of the TennCare enrollees.

Further, TCCN alleges the defendants' violation of the Equal Access Clause, as demonstrated by the April 2000 report from Price Waterhouse Coopers, which TCCN alleges that PWC found that TennCare is a financial unsound program and has based MCO reimbursement upon actuarially unsound premises, among other findings. TCCN alleges that as a result of the unreasonable Medicaid rate structure, there have been large scale withdrawals of physicians, hospitals and other Medicaid providers from the TennCare program.

TCCN alleges that the defendants violated the Equal Access Clause by establishing low reimbursement rates in order to promote the exclusion of TCCN, an African-American owned or managed MCO from TennCare instead of establishing rates to further the purposes of the Equal Access Clause. TCCN has suffered a particularized impact as the victim of the defendant's utilization of adverse selection rates and restraints on expenditure of reimbursement payments,

which were not contrived for economy or other appropriate purpose under the Equal Access Clause, but in order to drive TCCN out of TennCare.

TCCN requests a finding of violation of the Equal Access Clause, an injunction to remedy the continued failure to comply with 42 U.S.C. §1396a, an injunction to prohibit manipulation of the reimbursement rates causing harm upon TCCN or to disqualify it.

TCCN also relies upon 42 U.S.C. §1981 *et seq*., which prohibits persons from discrimination on the basis of race in making and enforcing contracts, in the application of laws, and in proceeding affecting contracts. As an African-American owned and managed MCO, TCCN is entitled to all the same rights as are white persons. TCCN alleges that the defendants, acting under color of state law, have purposely and intentionally discriminated against TCCN with regard to its contract in related laws and proceedings, because it is an African-American owned and management MCO. TCCN alleges that the defendants attempted to disqualify it from holding a TennCare contract on account of race. It is contended that the defendants retroactively reduced the adverse selection rates with the intent of financially disabling TCCN on account of race. It is averred that TCCN was denied the use of funds paid to it for performance of its contract to satisfy statutory net worth requirements in the same manner as white owned or managed TennCare MCOs on account of race. It is contended that the defendants orchestrated a continuing series of regulatory prohibitions, examinations, supervisions, rehabilitation and sanctions against TCCN for pretextual reasons to conceal the intent of the TennCare defendants to exclude TCCN from TennCare on account of race. It is alleged that the defendants manipulated the enforcement of the contract and the related laws in order to exclude TCCN from TennCare on account of race and refused on account of race to enter into negotiations or to give TCCN an opportunity to contract to provide TennCare services on the same basis as a white owned or managed MCO. This caused significant injury and damage to TCCN.

TCCN requests a finding of a violation of 42 U.S.C. §1981 *et seq*. and an injunction to prohibit continuing violation, including institution of a rehabilitation action against TCCN. It request that the defendants be required to extend to TCCN the same contract rights and benefits and to enforce equally as to TCCN and white owned or managed MCOs all of the provisions, laws and proceedings in connection with the TennCare contract.

TCCN also relies upon 42 U.S.C. §2000d *et seq*. contending that the defendants have intentionally discriminated against TCCN on account of race and through actions that have a

disparate adverse impact on TCCN. Under this provision, referred to as Title VI, no person on the ground of race, color, or national origin shall be excluded from participation and be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. TennCare receives federal financial assistance, as authorized under the Medicaid provisions of the Social Security Act. TCCN is a protected person under Title VI, because it is owned and operated by persons of African-American descent. TCCN alleges that the defendants have intentionally discriminated against it. The reimbursement rate setting methodology with respect to adverse selection and policies regarding expenditure of retroactive capitation rate increase and the twelve dollar, forty cent ($12.40) plan payments had a disparate impact on TCCN, as an African-American owned or managed MCO.

It is contended that the defendants do not have a substantial legitimate justification for their rate setting methodology or policies regarding use of TennCare payments. Their public justifications for the methodology and policies are pretextual and meant only to conceal their discriminatory motive to disqualify TCCN and injure it. The defendants have available to them alternative rate methodology for adverse selection funds and alternative policies for expenditure of temporary payments and allocation of high risk members which are compliant with the law and regulations governing TennCare and which will not have a disparate impact upon TCCN. TCCN has been harmed in its business and in its TennCare contract because of the intentional discrimination and disparate impact of the rate methodology and policies regarding expenditure of TennCare payments.

TCCN requests that the Court find violation of 42 U.S.C. §2000d and enjoin the defendants from continuing violation. TCCN requests that the Court require the defendants to cease their intentionally discriminatory conduct and to implement non-discriminatory rate methodologies and policies that do not have a disparate effect upon TCCN and African-American owned or managed MCOs.

TCCN also contends that the defendants have undertaken actions for the purpose and effect of depriving the plaintiff of its rights secured by the Fifth and Fourteenth Amendments to the United States Constitution and Article I, §21 of the Constitution of Tennessee, for which it seeks a finding of violation and an injunction against continuing violation.

STATUS OF TCCN v. STATE OF TENNESSEE

Answer of the State of Tennessee - The State of Tennessee filed an answer on May 31, 2001. The State denied a breach of an expressed contact between the parties. It denies that the claimant fully complied with the Contractor Risk Agreement in its original or amended form. The State relies upon the terms of the waiver. The State avers that section 3-1 of the Contractor Risk Agreement requires that TennCare conduct management of the Contractor Risk Agreement in good faith with the best interest of the State and its citizens, being the prime consideration, in addition to the simplicity of administration in the best interest of enrollees as required by 42 U.S.C. §1396a(a)(19).

The State relies upon various defenses including a failure to state a claim upon which relief can be granted, requiring dismissal pursuant to Tennessee Rules of Civil Procedure 12.02(6). The State contends that there has been no breach of the original or amended agreement. The claimant failed to provide notice to the State of its claim thirty calendar days (30) prior to filing the claim in accordance with T.C.A. §9-8-301, *et seq.*, and as required by Section 4-18 of the original agreement and the amended agreement. Further, the State contends that the claim should be dismissed, because the claimant agreed to the capitation rates contained within the original agreement and the amended agreement and is estopped to assert that it is entitled to capitation rates different from those set forth in the original agreement and amended agreement. The claimant had the right to terminate either agreement each year by providing notice of non-renewal to the State, but TCCN continued in the TennCare program for seven years (7). TCCN had the option to enter into a Risk Sharing Agreement to reduce its risk of loss, but chose not to enter into it until January 1, 2001.

The State contends that the claimant was a participant in a publicly funded program for which it received compensation in accordance with the original and amended agreement to the extent funds were appropriated by the General Assembly of Tennessee, pursuant to T.C.A. §9-1-116. The State contends that the Medicaid Act and applicable statutes and regulations were intended to benefit Medicaid recipients and to set forth the requirements for federal financial participation in the individual state Medicaid programs and not to benefit managed care organization, such as TCCN. Further, the State contends that the Health Care Financing Administration of the US Department of Health and Human Services approved the original agreement and the amended agreement, including the capitation rates contained therein.

The State has complied with the requirements of the Medicaid Act and applicable statutes and regulations, the TennCare waiver, the original agreement and the amended agreement. The claim should be dismissed, because TCCN is estopped, as it has claimed under oath in public filings and in sworn court responses that it has met and maintained its statutory required minimal net worth, per T.C.A. §56-32-212. As a not-for-profit corporation, TCCN is not guaranteed generation of a profit under either the original agreement or the amended agreement. The State contends that any financial difficulties experienced by TCCN were caused by its own mismanagement and by paying for optional services that were not required by the original and amended agreements to be provided to TennCare enrollees, such as vision and dental for adults.

TCCN has not fulfilled its obligations under the original agreement or the amended agreement, including but not limited to, the contractual obligation to act in good faith in the performance of the provisions under said agreements. Should the claimant be entitled to recover any amount, although denied, claimant may only recover actual damages provided in T.C.A. §9-8-307(d). TCCN would not be entitled to receive any alleged damages on behalf of others.

Removal - In June of 2001, the State of Tennessee served a Petition and Notice of Removal from the Claims Commission to the Chancery Court for Davidson County, Tennessee.

STATUS OF TCCN v. NEEL, USDC 3:00-1226

State Defendants' Motion to Dismiss - The defendants filed a motion to dismiss for failure to state a claim and lack of jurisdiction on February 7, 2001.

The State defendants contend that the plaintiff has no right of action under federal Medicaid law. Citing the decision in the case of *Blessing v. Freestone,* the State asserts that 42 U.S.C. §1983 only provides a cause of action to a plaintiff, who asserts a "violation of a federal right, not merely a violation of federal law." 520 U.S. 329, 340, 117 S.Ct. 1353, 137 L.Ed.2d 569 (1997).

Section 1902(a)(30)(A) of the Social Security Act, at 42 U.S.C. §1396a(a)(30)(A) does not provide a right of action to the plaintiff to challenge the payment rates in its contract as not made on an actuarially sound basis, because the Secretary of the United States Department of Health and Human Services, acting pursuant to statutory authority, has waived the application of this section in the context of the TennCare program. Further, the section does not mention and does not intend to confer any rights on managed care organizations. The section does not confer

a right of action on health care service providers and TCCN cannot allege a violation of the narrow standard of payment contained in the statute.

The State contends that section 1903(m)(2)(A)(iii) of the Social Security Act at 42 U.S.C. §1396b(m)(2)(A)(iii) provides no right of action to the plaintiff. It allows federal reimbursement of state Medicaid payments to managed care organizations, only where the payments are determined on a actuarially sound basis. This section governs the financial relationship between the state government and the federal government. It confers no rights of action on third parties. The provision is a ceiling on how much the federal government will pay and is intended to protect the federal treasury, not the managed care organizations.

Further, the State defendants rely upon the Eleventh Amendment, contending that the Court lacks jurisdiction to grant the relief requested. The limited *Ex parte Young* exception to state sovereign immunity for prospective injunctive relief against a state official to remedy ongoing violations of federal law does not extend to relief that in reality directly orders the payment of state funds.

The State contends that TennCare is an experimental program, functioning by virtue of a waiver granted under Section 1115 of the Medicaid Act, 42 U.S.C. §1315. Among the sections waived is Section 1902(a)(30). This waiver enables the TennCare program to establish capitation rates and negotiate participation contracts with managed care entities in accordance with the overall specifications of the TennCare program.

Section 1902(a)(30)(A) does not confer rights on the plaintiff or any other managed care entity. The provision deals with the utilization of and payment for those who provide services under a state Medicaid plan. TennCare is not operated pursuant to the State Medicaid plan, but rather as a separately authorized demonstration program. Accordingly, by its own terms, this section is not applicable in the TennCare setting. Even if it were, an MCO is not a service provider. There can be no enforceable right.

The State relies upon the decision in the case of *Evergreen Presbyterian Ministries, Inc., v. Hood*, No. 00-30498, 2000 W.L. 1808982 (5th Cir. Dec. 11, 2000) for the proposition that providers of service cannot enforce Section 1902(a)(30)(A). Courts have reasoned correctly that the recipients, not providers, are the intended beneficiaries of the statute. Earlier cases found an enforceable right for providers, based on claims of arbitrary and capricious rate setting or improper rate changes. The State defendants note that these rulings were largely based upon a

since-repealed statute or preceded the Supreme Court's more recent decisions defining when a federal statute can be construed to create a private right of action. The repealed statute was the Boren Amendment, formally Section 1902(a)(13)(A) of the Medicaid Act at 42 U.S.C. §1396a(a)(13)(A), which required states to set reimbursement rates for institutional providers that were reasonable and adequate. The right of action on the Boren Amendment was upheld in the Supreme Court decision in *Wilder v. Virginia Hospital Association,* 496 U.S. at 512 (1990) decision in *Blessing* narrowed the holding in *Wilder* by finding that Congress must unambiguously confer an individual entitlement upon each of the plaintiffs in the case. *Blessing*, 520 U.S. at 343.

The State defendants contend that Congress intended to preclude all such suits based upon payment rates under 1902(a) when it repealed the Boren Amendment. The State cited a House Report declaring that it was the Committee's intention that following enactment of this act (the Balanced Budget Act of 1997) neither this nor any other provision of Section 1902 will be interpreted as establishing a cause of action for hospitals and nursing facilities relative to the adequacy of the rates they received.

The State contends that section 1902(a)(30)(A) has a narrow construction with the statutory standard being only a rate sufficient to achieve the results sought by the provision, which is the availability of care and services equal to that available in the general population. This is not alleged.

As to any entitlement under Section 1903(m)(2)(A)(iii) at 42 U.S.C. §1396b(m)(2)(A)(iii), this section deals with financial relationship between the federal government and the state government. It deals with the circumstances under which federal funds will be made available to cover payment to states for services provided by managed care organizations under the state plan. This provision was intended for the benefit of the federal government, to ensure that MCO contractual payments do not exceed the "actuarially sound" standard. It creates no right of action on behalf of an MCO.

The State relies upon the Eleventh Amendment to preclude a federal court from ordering a state to pay money out of its treasury to the plaintiff. The state recognizes the limited exception in *Ex parte Young*, 209 U.S. 123, 28 S.Ct.441, 52 L. Ed. 714 (1908) for certain declaratory and injunctive relief to remedy an ongoing violation of federal law, applies only to prospective relief. The State has a continuing interest in the litigation whenever its policies and

procedures are at stake. *Idaho v. Coeur d' Alene Tribe of Idaho*, 521 U.S. 261, 269, 117 S.Ct. 2028, 138 L.Ed. 2d 438 (1997). The State's interest in avoiding suit is strongest where the judgment would compel the state to pay money out of the state treasury; protection from such judgments is the "central goal" of the Eleventh Amendment. *Christy v. Pennsylvania Turnpike Commission*, 54 F.3d 1140, 1145 (3d Cir. 1995). The State contends that the sole purpose of the TCCN complaint against Warren Neel, et al is to obtain more money from the State of Tennessee.

TCCN Memorandum in Opposition - The plaintiff responded with a memorandum in opposition to the defendants' motion to dismiss. TCCN stated that the gravamen of the action is that the capitation rate set by the State of Tennessee for TennCare managed care organizations is not actuarially sound in violation of the Medicaid Act. This was established by an actuarial study commissioned by the State of Tennessee in 1999. TCCN contends that its rights were violated then and now.

TCCN noted that its amended complaint dismissed the defendant Frieda Wadley, M.D., and focused upon the capitation rates in effect as of the date of the filing of the complaint and thereafter. The provision of the Medicaid Act upon which it was relying was identified as 42 U.S.C. §1396b(m)(2)(A)(iii) and 42 C.F.R. §434. 23(a) and 42 C.F.R. §434.61.

TCCN acknowledges that through the waiver, certain provisions of the Medicaid Act do not apply to the operation of TennCare. However, TCCN contends that other provisions of the Medicaid Act apply and are not excused. For example, the waiver did not excuse the requirement to have a state Medicaid plan as required by 42 U.S.C. §1396a. State only sought relief from specified requirements of the Medicaid Act through its Section 1115 application. The waiver only applied to specifically designated provisions of the Medicaid Act. TCCN states that the TennCare waiver only granted a waiver to the Upper Payment Limit for Capitation Contracts to the extent required by 42 U.S.C. §1396a(a)(30)(A). This phrase is not mentioned in this section.

TCCN contends that it has standing to bring the action against the State officials pursuant to 42 U.S.C. §1983. It contends it has been deprived of rights secured to it by the laws of our country. TCCN relies upon the United State Supreme Court decision in the case of *Wilder v. Virginia Hospital,* 496 U.S. at 501 (1990), for the proposition that medical providers have standing to sue under section 1983 to enforce provisions of the Medicaid Act. In *Wilder*, it was

held that a health care provider could bring an action under section 1983 to enforce the mandate found in the Boren Amendment, 42 U.S.C. §1396(a)(13)(A). The Boren Amendment has been repealed. It required that Medicaid participating states pay rates that are reasonable and adequate to meet the costs, which must be incurred by efficiently and economically operating facilities. The decision in *Wilder* was followed thereafter in various federal courts to enforce the Boren Amendment. In some states, the decision in *Wilder* has been extended to entertain actions to enforce other provisions of the Medicaid Act. TCCN contends that the reliance by the defendants upon the decision in *Blessing v. Freestone*, *supra*, and *Suter v. Artist M.*, 503 U.S. 347 (1992) is not appropriate. TCCN contends that its claims are rooted firmly in a clear statutory requirement for the calculation of capitation rates according to a statutory formula (actuarial soundness of contractually required capitation rates) rather than a legislative statement of substantial compliance.

TCCN contends that the purpose of 42 C.F.R. §434.23(a) is to put the MCO on notice of the actuarial basis of the capitation rate. This would provide no benefit to either the state or federal government. The provisions of 42 C.F.R. §434.61 require that the agency must determine that the capitation fees and other payments provided for in a contract are computed on an actuarially sound basis. This section would benefit the MCO, the state and federal governments. TCCN contends that the issue is not the establishment of a floor or ceiling, but rather that the rates be firmly rooted and calculated in an actuarially sound manner.

TCCN contends that the statutory and regulatory demand of actuarially soundness is not precatory. It is clearly mandatory. Language such as "no payment shall be made" and "the contract must specify" established this. TCCN contends that the concept of actuarial soundness is precise and subject to easy judicial understanding and enforcement.

TCCN contends that the requirements of 42 U.S.C. §1396a(a)(30)(A) provide enforceable rights through section 1983. It contends that this section was not waived in its entirety, but only to the extent that the Medicaid Act imposed an upper payment limit on the amount of the capitation fees to be paid to managed care organization. TCCN contends that this provision may apply to persons beyond Medicaid beneficiaries, citing the decision in *Wilder*. TCCN contends that the repeal of the Boren Amendment was not intended to preclude all actions based upon this section. It quotes the House Report as referencing the preclusion of actions by hospitals and nursing facilities. It did not mention MCOs.

TCCN disputes the position of the state defendants that the Eleventh Amendment represents a jurisdictional bar. Citing *Ex parte Young*, TCCN states that the Eleventh Amendment does not bar a suit against a state officer in his or her official capacity for violations of the United States Constitution. Sovereign immunity bars retroactive monetary relief, but suits to enjoin state officials may be brought. TCCN is only focusing upon the conditions and circumstances in existence at the time of the filing of the complaint and thereafter and not retrospectively. TCCN is only seeking injunctive relief. It is not suggesting any recovery, but rather a recalculation of the capitation rates.

State Defendants' Reply Brief - The defendant state officials filed a reply brief in support of their motion to assess.

The state defendants noted that with the filing of its brief in response, TCCN filed an amended complaint.

The state defendants reiterated their position that TCCN cannot maintain a right of action under section 1902(a)(30)(A) because the provision does not apply to TennCare by virtue of the terms of the TennCare demonstration. Further, even it if it applied, it does not cover payments to an MCO. Further, the plaintiff could not allege a violation of the substantive standard of the provision.

The state defendants stated that TCCN cannot satisfy the *Blessing* requirement that to support a right of action a statute must be intended specifically to benefit the plaintiff. 520 U.S. 329, 117 S.Ct. 1353, 137 L. Ed. 2d 269 (1997). There is no showing that Congress specifically intended the substantive requirements of the section to benefit managed care entities. The legislative history of the repeal of the Boren Amendment further demonstrates that managed care entities cannot enforce this action.

As to any right of action under Section 1903(m), it does not impose the substantive requirements that TCCN alleges. It limits federal reimbursement to manage care contracts that provide for payments no higher than is fiscally prudent and actuarially sound. The language does not recite a requirement of actuarially soundness as a payment floor to protect payees. It establishes a ceiling and not a floor.

The state defendants rely upon an interpretation by HCFA in which it was stated: "as long as a state follows accepted actuarial principles, it is free to determine what constitutes a "sound actuarial basis." DHHS Final Rules 48 Fed. Reg. 54013, 54018 (November 30, 1983).

The plaintiff acknowledges the preparation of the actuarial study by Price Waterhouse Coopers. It contends that the rates were set too low, but it does not deny that PWC prepared its report based upon accepted actuarial principles. Accordingly, the state, in its discretion, set the rates and TCCN may not contest them.

The state defendants continue to rely upon the Eleventh Amendment, in that the TCCN claim, if taken to its reasonable conclusion, would permit the plaintiff to obtain more money from the State of Tennessee in a future proceeding.

Memorandum and Order Granting Motion - United States District Court Judge Todd J. Campbell granted the defendants' Motion for Summary Judgment and dismissed the suit of TCCN in April of 2001. In his memorandum, Judge Campbell noted that the Medicaid statute does not contain a private cause of action. A plaintiff must assert the violation of a federal right and not merely a violation of federal law. §1983 is not available to enforce a violation of a federal statute where congress has foreclosed such enforcement of the statute in the enactment itself and where the statute did not create enforceable rights, privileges or immunities within the meaning of §1983.

The Court noted the three-part test for determining whether a particular statutory provision gives rise to a federal right. The test was established in the *Wilder* case and further discussed in the *Blessing* case. First, Congress must have intended that the provision in question benefit the plaintiff. Second, the plaintiff must demonstrate that the right assertedly protected by the statute is not so "vague and amorphous" that its in enforcement would strain judicial competence. Third, the statute must unambiguously impose a binding obligation on the states. The asserted right must be couched in mandatory, rather than precatory terms.

The Court noted that the TennCare program is an alternative to Medicaid and a contract between Tennessee and the federal government. TennCare recipients are third party beneficiaries of that contract. Federal law authorizes the Secretary of the Department of Health and Human Services to waive certain provisions of the Medicaid law as necessary to carry out "alternative" health care programs, such as TennCare. 42 U.S.C. §1115. The defendants are required to comply with all provisions of the Medicaid Act that have not been specifically waived.

The plaintiff alleges that the defendants must comply with 42 U.S.C. §1396b(m)(2)(A)(iii), which requires the capitation rates paid to managed care organizations,

such as the plaintiff, be calculated in an "actuarially sound manner." The plaintiff contends that the defendants have failed to comply with certain implementing regulations at 42 C.F.R. §434.23(a) and §434.61. Plaintiff further contends that the defendants must comply with 42 U.S.C. §1396a(a)(30)(A) which requires the state to provide certain methods and procedures relating to the use of and payment for care and services as necessary to assure that payments are consistent with efficiency, economy and quality of care.

As to 42 U.S.C. §1396a(a)(30)(A), the Court found that this statute was not intended to benefit managed care organizations. Noting that there may be a split of authority as to whether health care providers were intended beneficiaries of §1902(a)(30), the Court states that the plaintiff is not a health care provider. There is no evidence that Congress or the courts have extended the intended beneficiaries of the section beyond health care providers to managed care organizations.

As to 42 U.S.C. §1936b(m)(2)(A)(iii), the Court finds that this statute was intended to set forth the requirements for financial participation in a state's Medicaid program, not to benefit managed care organizations. This statute creates no private right of action. This section is not enforceable by TCCN either by its own terms or through the use of §1902(a)(30)(A).

TCCN Final Brief on Appeal - The plaintiff TCCN filed an appeal with the United States Court of Appeals for the Sixth Circuit. In its final brief, it reiterated its positions with the respect to the enforceability of the actuarial soundness provisions and equal access provisions, as an intended beneficiary of the subject statutes and implementing regulations.

TCCN states that MCOs are the heart of the Medicaid Act's promise of equal access. The downward pressure to constrain spending and the beneficiaries upward pressure to maximize pressures converge on MCOs, crushing them like a vise.

TCCN contends that the District Court did not apply the *Wilder* analysis in its decision making, as should be required in the analysis of a private right of action situation.

TCCN notes that the First, Third, Seventh and Eighth Circuits have held that providers are intended beneficiaries under the Equal Access Provision because it concerns their payment for care and services to Medicaid beneficiaries.

State Defendants' Reply Brief - In its reply brief, the state defendants restated their arguments submitted below and encouraged affirmation of the decision of the District Court. TCCN filed an appellant's final reply brief in October of 2001.

STATUS OF TENNESSEE COORDINATED CARE NETWORK, INC., v. WARREN NEEL, JOHN F. TIGHE, ANN B. POPE and MANNY MARTINS

This suit was originally filed in the Chancery Court for Davidson County, Tennessee, as Case No. 01-12-I. It was removed to the United States District Court for the Middle District of Tennessee at Nashville and became Case No. 3:01-0126.

Answer of the State Defendants - The defendants filed an answer to the complaint in March of 2001. The state defendants aver that the management, administration, control and staffing for TCCN were provided by Medical Care Management Company and/or Access Health Systems. It is admitted that officers and agents of TCCN and its management companies have referred to those businesses as African-American business entities and minority business enterprises. Any reference by the defendants in that regard were based upon such representations, rather than independent knowledge of the racial makeup of the owners, board members, officers, agents, or employees of those companies. It is admitted that TCCN is a managed care contractor, participating in Tennessee's federally approved demonstration waiver project, pursuant to §1115 of the Social Security Act at 42 U.S.C. §1315. TCCN is required to provide services to TennCare enrollees, pursuant to the terms and conditions of the state's Medicaid waiver. The TennCare program includes enrollees who Medicaid recipients and those who are either uninsured or uninsurable citizens of the State of Tennessee. It is denied that TennCare is a "Medicaid Program", and it is averred that its operation and administration are subject to a substantially different set of requirements than those which govern the operation of a typical "Medicaid Program."

TennCare enrollees either select or are assigned to an MCO in TennCare. The MCO receives a monthly per capita payment in return for the coverage it provides to an enrollee. At the end of 1998, TennCare had slightly fewer than one million, three hundred thousand (1,300,000) enrollees.

On or about December 28, 1995, TCCN then known as Tennessee Managed Care Network (TMCN), was requested to cure within twenty days (20), its net worth deficiency of five million, five hundred, eighty-eight thousand, one hundred, fifty dollars and ten cents ($5,588,150.10), which deficiency was reflected in the Tennessee Department of Commerce and Insurance December 28, 1995, examination of TCCN, as of August 31, 1995. This figure was

subsequently adjusted downward to four million, eight hundred, sixty-seven thousand, two hundred, eighty-five dollars and thirteen cents ($4,867,285.13). The December 28, 1995 examination report disallowed a disputed contingent receivable claimed by TCCN as a part of its net worth in the amount of twenty-one million, two hundred, forty thousand, five hundred, thirty-seven dollars ($21,240,537.00). TCCN sold certain assets to MCMC. The March 7, 1997 examination of TMCN (later TCCN) from September 1, 1995 to March 31, 1996 reflected an adjusted net worth of eight million, eighty-two thousand, nine hundred, sixty-seven dollars ($8,082,967.00) above the required two million, one hundred thousand dollar ($2,100,000.00) statutory net worth at that time. It is denied that the net worth deficiency was caused solely by changes in adverse selection payments. It is denied that changes in adverse selection payments resulted in a dollar impact on TCCN of seventeen million dollars ($17,000,000.00) in 1998. TCCN submitted a July 1999 corrective action plan which was incomplete.

MCOs were given guidelines for submission of an expenditure plan with regard to the twelve dollar, forty cent ($12.40) payments. TCCN's corrective action plan could not be approved until December 1999, due in part to TCCN's submission of an incomplete plan in July of 1999, as well as TCCN's subsequent failure or refusal to provide timely and complete information. The defendants became increasingly aware of the problems with the new claims processing system during January and February of 2000. TCCN made advance payments to providers after the claims processing system failed to meet processing claims as required by its contract.

The Peterson Group issued a review dated January 17, 2000, regarding TCCN's processing of provider claims and compliance with the prompt pay requirements during a period from January 1, 1998 through March 31, 1999. The Peterson Group concluded that for that period, TCCN generally appeared to be processing claims in accordance with the TennCare contract. This review concerned the old or prior claims processing system, employed by TCCN before its conversion to its new claims processing system in December of 1999. The January 2000 Peterson Review did not address a conversion to the new system.

In early 2000, the Mercer Company was asked by the Department of Finance and Administration to perform an operational review of all MCOs in TennCare, including their claims processing systems. Numerous major problems with TCCN's new claims processing system quickly became apparent. The Tennessee Department of Commerce and Insurance

requested that consultants from Mercer Company specifically review TCCN's new claims processing system during February 2000. Officials participated in a number of meetings.

Tennessee Department of Commerce and Insurance employees employed a standard and accepted auditing method for confirming accounts receivable claim by TCCN, by contacting providers from whom TCCN claimed receivables, in order to confirm these receivables.

After previous requests were ignored, TCCN was asked to provide information about Access Health Systems on August 25, 1999. Access Health Systems is related to TCCN. A subpoena was issued on or about January 21, 2000. A letter of examination dated February 3, 2000 was entered into. The state defendants deny that TCCN was compelled to enter into it. TCCN did not agree to an order of supervision as of March 2000 but did agree to a letter of examination on March 6, 2000 with many similar terms. TCCN's March 2000 capitation payment was paid on March 7, 2000. TCCN filed a petition in the Secretary of State's Administrative Procedures Division in November of 2000. TCCN filed an action in the Tennessee Claims Commission on or about December 11, 2000 and a federal court action on or about December 13, 2000.

The state defendants aver that TCCN has failed to state a claim upon which relief can be granted. The defendants have not discriminated against TCCN under either a theory of intentional discrimination or under a disparate impact theory. TCCN, as an MCO, has no right of action under 42 U.S.C. §1396a(a)(30)(A), which was designed to ensure equal access to medical services by Medicaid beneficiaries. TCCN has no protected interest under that provision or representation of third party standing to sue on behalf of Medicaid beneficiaries. The state defendants rely upon the applicable statutes of limitation, the Eleventh Amendment and the doctrine of sovereign immunity.

The state defendants contend that there is no private right of action under regulations promulgated pursuant to Tile VI. By filing a substantially similar claim in the Tennessee Claims Commission, TCCN has waived its right to a federal cause of action. TCCN asserted a claim identical to that stated in Count I of its complaint in another action pending before the same federal court. TCCN has failed to state any protected interest for which process is due under the United States or Tennessee Constitutions. The state defendants rely upon all defenses available to them under the Tennessee Insurance Law, T.C.A. §56-1-101 *et seq*., and the Medical Assistance Act of 1968, T.C.A. §71-5-101 *et seq*. Further, the claims are barred by the defenses

of waiver, release and/or estoppel. The plaintiff lacked standing to bring the claims and the plaintiff has failed to join indispensable parties.

State Defendants' Motion for Summary Judgment - The defendants filed a motion for summary judgment in July of 2001. The motion was support by the affidavits of Manny Martins, Deputy Commissioner, TennCare Division of the Department of Commerce and Insurance; John F. Tighe, Deputy Commissioner of the Tennessee Department of Finance and Administration for the office of Health Services; and Patricia L. Newton, Assistant Commissioner, TennCare Division of the Department of Commerce and Insurance. Further, and filed in support of the motion were the following: KPMG Peat Marwick letter of June 4, 1993 to Manny Martins; Excerpts from a Contractor Risk Agreement between the State of Tennessee and a contractor, dated September 11, 1995; the Order and Memorandum, dismissing the suit of *Tennessee Coordinated Care Network v. Neel*, USDC No. 3:00-1226.

In their Memorandum of Law in Support of their Motion for Summary Judgment, the defendants contend that they are entitled to judgment as a matter of law on TCCN's Equal Access claim on the basis of issue and/or claims conclusion. Summary judgment was also appropriate for TCCN with respect to its claim under §1981 and Title VI, because the undisputed facts, demonstrated within supporting affidavits and other documents, established the absence of discrimination, intentional or otherwise, and that numerous administrative dec isions inured to the benefit of TCCN. TCCN does not allege what type of due process rights were infringed nor any protective rights or procedures of which it was deprived, making summary judgment appropriate for those claims as well.

In their statement of facts from the affidavits of the Martins, Tighe and Newton, the state defendants established the background for the implementation of the Tennessee TennCare program. The Health Care Finance and Administration (HCFA), now known as the Center for Medicare and Medicaid Service (CMS), promulgated federal guidelines for the Medicaid program, established in 1965, as a jointly funded federal and state program providing medical assistance to qualified lower-income individuals. Each state designs and administers its own Medicaid program pursuant to a state plan approved by HCFA. States may propose demonstration projects for alternative methods of delivering health care services. If approved, HCFA grants waivers for federal Medicaid laws to the extent necessary to implement the demonstration project. In 1993, Tennessee became one of the first states to request a waiver to

convert its entire acute care Medicaid program. The waiver was approved for a five-year period, which was later extended. Tennessee began operating its demonstration project, known as TennCare, on January 1, 1994.

Tennessee sought the waiver to accomplish two complimentary goals. First, the state wanted to expand the reach of its Medicaid program beyond the federal eligibility standards, so as to provide services for uninsured and uninsurable persons in Tennessee. Secondly, the state wanted to improve the efficiency of its health care delivery by introducing certain market principles into the administration of its Medicaid program that would not have been permitted under the federal laws at that time. An example would be the setting of overall capitation rates for managed care delivery of health care services. The state was concerned with escalating Medicaid costs which were growing faster than the supporting tax base and the financial inefficiencies of the Medicaid program, in part due to its lack of emphasis on preventive care. At the time of the memorandum, the TennCare program was providing managed health care to approximately one million, three hundred thousand (1,300,000) Tennesseans and was only one of two programs of its type in the country.

There are two state agencies involved in the operation and oversight of the TennCare program. The Department of Finance and Administration is the single state agency responsible for administering the program. The TennCare Bureau, within the TDFA, actually administers the TennCare program to ensure that appropriate health care services are delivered to enrollees. Defendant Warren Neel was appointed as Commissioner of TDFA on June 30, 2000. The defendant John F. Tighe was appointed as Deputy Commissioner of TDFA on September 23, 1999. The responsibility of the TennCare Bureau includes policy development, direction and determination, negotiating contracts and contract amendments with the various managed care organizations, establishing capitation and other reimbursement payment rates for the participating MCOs, and reviewing the financial filings required of the MCOs by statute and their contracts with the state.

The TennCare Division of the Tennessee Department of Commerce and Insurance was created to conduct the financial and systems oversight of the MCOs participating by contract in the state's TennCare program. The defendant Ann B. Pope was appointed Commissioner of the Tennessee Department of Commerce and Insurance on November 1, 1999. The defendant Manny Martins was appointed as Deputy Commissioner of the Tennessee Department of

Commerce and Insurance on October 2, 2000. The responsibilities of the TennCare division include oversight and examination of the participating MCOs to ensure compliance with all statutory and contractual requirements, and examination, supervision or rehabilitation of any MCOs that fail to comply with one or more requirements.

The first step in implementing the new TennCare program was the establishment of an appropriate capitation rate. Mr. Martins, then Director of the TennCare Bureau and David Manning, then Commissioner of the Tennessee Department of Finance and Administration, drew on a variety of resources in determining the rates that the MCOs would be willing to accept in exchange for delivering the required package of health care services. The state commissioned the consulting firm KPMG Peat Marwick LLP that proposed a capitation rate based upon actuarially experience from the Medicaid program and the State of Tennessee employees' health program. Complete actuarially data was unavailable. With part of the purpose being to provide coverage for uninsured and uninsurable groups, which had not historically received health coverage, complete actuarially data was unavailable.

The TennCare program initially contemplated community-based rates. However, a single statewide rate was implemented based on input from the Tennessee Medical Association and because the approach was thought to be reasonable. Other factors that went into calculating the initial capitation rate included use of a Harkey Study on the average capitation rate in Tennessee and adjustments for anticipated managed care savings and charity care. The capitation rate was then divided among various "rate cells" which applied to different age groups. An independent report completed by KPMG Peat Marwick LLP concluded that "overall, our review found the TennCare benefit package to be reasonable and the methodology utilized in the calculation of the adjusted cost per eligible month {of the future TennCare recipients} to be actuarially sound."

Crucial to the successful implementation of the program was the transformation of the former Medicaid program with the exception of long term care into a complete managed care system with the qualified MCOs with adequate networks of providers to meet the health care needs of all TennCare enrollees. Director Manny Martins sent out information to all qualified MCOs operating commercially in the state. Director Martins spoke with every MCO that expressed interest and negotiated contracts in the fall of 1993 with all MCOs, wishing to participate. TCCN, then operating as Tennessee Managed Care Network, was one of those. The TennCare Bureau was particularly interested in having TMCN participate in the new program

because it was the only HMO at that time providing health care to the state's former Medicaid enrollees, and therefore was uniquely situated to provide services under the new managed care system.

Director Martins met with representatives of all interested MCOs and explained the structure of the new program and the rates that would be paid to participating MCOs. He maintained consistency throughout his negotiations with the MCOs. If one MCO negotiated a substantive change in the terms of the proposed contract, Martins would make the change in all of the MCO contracts. The only substantive difference in the original contracts related to the two types of carriers originally participating in the program. At the inception of TennCare, MCOs could chose to provide services as either a preferred provider organization or a health maintenance organization. Both received a capitation rate from the state for each TennCare enrollee, which could be more or less than it actually cost of delivering health care services for the corresponding period. PPOs operated under "provider risk agreements" in which the provider shares the risk of excess costs on a prorated basis, but the PPO's were limited in the amount of surplus they could retain. HMOs operated pursuant to "contractor risk agreements" under which they bore the full risk of excess costs, but enjoy the full benef it of any profit.

When the TennCare program began, TMCN and six other MCOs began as HMOs. The other five plans began as PPOs. By January 1, 1997 all TennCare plans had to convert to operating as HMOs. Thereafter, all MCOs operated under the same agreement with the state and were subject to the same regulatory regime.

The originally negotiated contracts were uniformly revised as of September 1, 1995, and that version of the Contractor Risk Agreement remained in place until June 30, 2001 for all participating MCOs. During that time, the Bureau negotiated thirteen amendments to the plan which were identical for all participating MCOs. The MCOs were offered the choice of three different risk-sharing contract options. All had the choice of a full risk plan (like the original one) or one of two different risk-sharing arrangements, in which the state would share the risk and profit with the MCO beginning at either the first dollar or after a two percent corridor. TCCN elected to continue operating under a full risk contract until January 1, 2001, at which point it elected one of the risk-banding options.

After the conversions of all MCOs to HMOs in 1996, all the TennCare MCOs have operated under the same contract terms. Effective July 1, 1996, a separate category of MCO,

referred to as Behavioral Health Organizations was established with contracts to provide mental health services.

Unique circumstances have triggered application of particular contract terms and resulted in deviations from the standard application of the contract. The first of these was when MCO Xantus entered into a voluntary rehabilitation on March 31, 1999. In order to protect the interest of the providers with whom Xantus had contracted and the individual enrollees, the State of Tennessee began operating Xantus under a "non-risk" contract, under which the state had agreed to absorb any costs in excess of the capitation rates. On another occasion, two different MCOs, VSHP and John Deere, announced their intentions to terminate their participation in the TennCare program. Faced with the possible loss of coverage for more than one half of the TennCare enrollees with VSHP's and John Deere's departures, the TennCare Bureau declared a State of Exigency for both plans. Under the terms of the TennCare contract, the state may take certain measures to prevent a public exigency that would result from an MCO's departure from the program. The state can require an MCO to continue operating in the TennCare program under one of two exigency arrangements. The type chosen by VSHP and John Deere reimbursed them for its cost. Both operated under exigency contracts until July 1, 2001, after which both plans reentered the TennCare program on a voluntary basis.

Tennessee regulates HMOs to protect the interest of the enrollees, providers and shareholders of the HMOs as well as the general public. The State of Tennessee HMO Act requires that all HMOs within the TennCare program pay provider claims promptly. This means by paying ninety percent (90%) of provider and other "clean claims" (i.e., claims for which no further inquiries are required) within thirty days of receipt by the HMOs, and ninety-five percent (95%) of all provider claims within sixty days (60). T.C.A. §56-32-226(b)(1). The terms of the current provider risk agreements impose even higher standard, requiring HMO's to pay ninety-five percent (95%) of "clean claims" within thirty days (30), and all provider claims within sixty days (60).

MCOs in the TennCare program must prove they meet the state's financial net worth and working capital requirements. T.C.A. §56-32-212(a). Net worth is statutorily defined as the excess of total admitted assets over total admitted liabilities, but the liabilities shall not include fully subordinated debt approved by the Commissioner. The statute lists approved admitted assets and provides a formula for calculating each MCO's statutory net worth requirement.

Consistent with the National Association of Insurance Commissioners' standards, receivables more than ninety days (90) old are excluded from the lists of admitted assets. The Tennessee Department of Commerce and Insurance initially permitted MCOs to include adverse selection receivables due from the State of Tennessee among their admitted assets, even if they were more than ninety days (90) old. However, the Tennessee Department of Commerce and Insurance advised all of the MCOs that it was eliminating this practice in April of 1999.

Under the terms of the TennCare contract, an MCO's failure to comply with the prompt pay or net worth requirements, or with any of other statutory or contractual requirements, may result in a withholding of up to ten percent (10%) of the monthly capitation rate until the problem is rectified. The contract requires a non-compliant MCO to submit a corrective action plan for approval and allows for the termination of any MCO contract with or without cause. The Commissioner of the Tennessee Department of Commerce and Insurance has a variety of regulatory mechanisms for overseeing the operations of MCOs and protecting the interest of their providers and enrollees. The Commissioner has the discretion to perform audits, investigations and examinations of all MCOs and may supervise some or all of the operations of a non-complaint MCO. The Commissioner may suspend or revoke an MCO's certificate of authority to operate as an HMO, or file a petition in the state's Chancery Court to rehabilitate or liquidate an MCO pursuant to several statutory grounds, or being "in such condition that the further transaction of business would be hazardous financially to its policy holders, creditors, or the public." T.C.A. §56-9-301 - 306.

After letters of intent with the various MCOs were signed at the beginning of the TennCare program, the TennCare Bureau began the task of assigning enrollees to the various MCOs. Enrollees were asked to rank the MCOs in their order of preference in the event a particular MCO was not ultimately available. The Bureau mailed out ballots to all eligible TennCare enrollees with the choices of health plans available to them in their geographic area. The ballot explained that any enrollee who did not select a plan would be assigned to one. Only forty to fifty percent of the enrollees submitted completed ballots. The state assigned all remaining enrollees according to the same percentages of those selected in the completed ballots. This method was explained to the participating MCOs in advance. TCCN benefited from this arrangement because it received the second highest number of ballot selections and therefore

received the second highest percentage of enrollee who did not make an election. Thereafter, enrollees who entered the program were assigned on a strictly pro rata basis to the various plans.

In December of 1999, VSHP reached a program-wide cap, established to ensure that no single MCO provided services to more than forty-three percent (43%) of TennCare's program enrollment cap of 1.5 million or fifty percent (50%) of the actual TennCare enrollment. Accordingly, it was unable to accept new members through 2000. In March of 1999, Xantus entered voluntary rehabilitation and also was closed to new enrollees, leaving TCCN as the only state-wide plan open to new enrollees, although two regional plans were also open. With the overall program changes effective July 1, 2000, the TennCare Bureau instituted a new program-wide enrollment size limit for each MCO of one hundred, fifty thousand to three hundred thousand ($150,000 – 300,000) enrollees. A plan may not accept new members during an open enrollment season once it reaches ninety percent (90%) of its enrollment limit (270,000 enrollees). When the limit was implemented, TCCN had over three hundred, fifty thousand (350,000) enrolled and was therefore capped for new enrollees.

The initial assignment of enrollees by the TennCare Bureau was neutral, in that the Bureau did not examine or consider the health status of the enrollees it assigned to the participating MCOs. The plans therefore found themselves with varying percentages of enrollees with disproportionately high medical costs, such as patients in need of organ transplants. The Bureau compensated for the extra cost of providing care to those enrollees, known collectively as "adverse selection enrollees" by means of supplemental quarterly "adverse selection" payments paid from a collective annual fund of forty million dollars ($40,000,000.00). The Bureau calculated its initial adverse selection rates by working with the then Medical Director, Dr. John Gore, to develop a list of the diagnoses that had been the most costly under the Medicaid program. The Bureau then compared each adverse selection diagnosis against an MCO's total population, and any MCO that had a higher than average percentage of one of the designated diagnosis codes received an adverse selection payment. The amount of the adverse selection payment was the average difference between the capitation rate and the actual average cost of treating that particular diagnosis, subject to a program cap of forty million dollars ($40,000,000.00) for such payments, allocated on a pro rata basis among the plans if the total liabilities exceeded the available pool of funds. The adverse selection categories were provided to the MCOs by letter.

Prompted by concerns that the adverse selection rates were not accurately reimbursing the actual adverse costs born by TennCare MCOs, the Bureau commissioned a study in 1997 by the William M. Mercer Consulting Firm to examine its adverse selection rates. The TennCare Bureau notified all MCOs of the commissioned report and each MCO agreed contractually that the Bureau might change its adverse selection rates as of July 1, 1997. The Bureau also solicited input from the MCOs on the proposed changes.

One component of the new methodology, which was effective July 1, 1997, addressed a major concern about the old method. Under the original methodology, MCOs received a supplemental payment based on the number of people with a qualifying high cost chronic condition regardless of the number of people expected to have those conditions within each plan. Because the capitation rates already reflected the costs of both high and low cost members, plans that did not have more than their proportional share of those members with high cost chronic conditions could receive a disproportion amount of payment based only on the number of individuals with a condition. Therefore, under the original adverse selection methodology, plans often received an adverse selection payment without being truly adversely selected relative to the other plans, and thus received a double benefit. This change was approved by HCFA.

When the new adverse selection methodology was implemented retroactive to July 1, 1997, the same annual amount of forty million dollars ($40,000,000.00), available for adverse selection, was now being redistributed according to the findings of the Mercer report. Some MCOs benefited from the redistribution while others, including TCCN did not. Exacerbating the impact of the change in adverse selection methodology was the fact that some MCOs, such as TCCN, owed the state money from having received eighteen months (18) of adverse selection payments based on the old rate. Recognizing that for some plans, including TCCN, this payback obligation would be onerous, the TennCare Bureau authorized a one time infusion of an additional thirteen million, four hundred thousand dollars ($13,400,000.00) into the adverse selection pool, which would effectively ameliorate that burden. This one time infusion benefited TCCN more than any other MCO, and TCCN had to reimburse the state only thirty-three thousand, five hundred, twenty-four dollars ($33,524.00) compared to the original amount due of eight million, one hundred, seventy-nine thousand, nine hundred, twenty-nine dollars ($8,179,929.00).

Even after this infusion, certain plans, including TCCN, continued to experience problems in meeting their contractual obligations. TCCN developed a statutory net worth deficiency by the end of the 1998 reporting period, caused in part by the change in adverse selection rates. Contributing to this net worth deficiency was the recalculation, by TCCN's actuary, of TCCN's incurred but not reported liabilities for 1999. The consultant estimated an unexpected IBNR "upswing" of nine million dollars ($9,000,000.00) for 1999. TCCN's financial difficulties were eased further by the adoption of a one time two percent (2%) retroactive increase in the capitation rate effective July 1, 1999. This extraordinary measure had the effect of giving all MCOs a lump sum payment covering, to a significant degree, services for which MCOs had already paid providers. Thus, the payments provided MCOs the opportunity to strengthen their financial condition. To ensure that this effect would be realized, the Bureau imposed the condition on all MCOs that the two percent (2%) increase could not be used for increasing management fees. The MCOs also agreed to waive any objections to the rate methodology used from January 1, 1994, through June 30, 1999.

In 2001, the TennCare Bureau further refined and greatly enhanced its capitation rates, after receipt of the results of a second report prepared by Price Waterhouse Coopers for the Comptroller of the State Treasury and TennCare Bureau. The PWC report recommended that the capitation rates reflect both regional utilization differences and risk factors for each individual plan. The PWC results revealed significantly lower utilization of medical services in certain regions of the state and particularly in Shelby County, as well as substantially different risk factors among the MCOs. The Bureau elected not to implement the full adjustments but to limit the adjustments both for regional utilization and risk adjustment within five percent (5%) corridors. The overall increase in capitation rates (excluding Medicare/TennCare dual enrollees, who received a benefit change) in the State's 2001 fiscal year was approximately twenty-four percent (24%), and resulted in substantial increases for all MCOs. Although TCCN's increase was less than the average MCO's increase, its increase relative to its risk was actually higher because of the State's decision to limit the adjustments and not to adjust the rates to the full extent suggested by the actuarial data.

Based on the PWC recommendations, effective July 1, 2001, the TennCare Bureau incorporated adverse selection factors into the capitation rates, rather than paying them separately, and included the forty million dollar ($40,000,000.00) adverse selection funding in

the funding available for MCO capitation payments. Under the new capitation payment methodology, risk scores are assigned to each plan based on the healthcare status of its population compared to the TennCare program average. These risk scores are used to compute adjustments to the capitation rate within the corridors described above. The risk scores will be re-determined and rates will be recalibrated under any major shift in enrollment, such as after an MCO open enrollment period.

After the initial capitation rates were established, the Bureau periodically sought and received funding approval from the General Assembly for increases in the capitation rates. In July, 1994, the Bureau implemented a five percent (5%) capitation rate increase for all participating MCOs, effective retroactively to January 1, 1994. On July 1, 1995, a five percent (5%) capitation rate increase went into effect for all MCOs, followed by a supplemental retroactive 4.5% increase on September 27, 1995, as an incentive for all MCOs to assume new administrative requirements under the revised standard contract.

Effective July 1, 1996, TennCare entered into contracts with Behavioral Health Organizations to deliver behavioral health and substance abuse services to the TennCare population. Because those benefits were removed from the MCOs required benefits, the Bureau carved out seven dollars, fifty-three cents ($7.53) from each rate cell paid to all MCOs. Effective that same date, a five percent (5%) capitation rate increase was provided to the MCOs, one percent (1%) of which was set aside, for the benefit of all MCOs, for the exceptional cost of new medical technology. Effective July 1, 1997, the one percent (1%) set aside was rolled into the rates along with a three percent (3%) funding increase. The increase was allocated in individual adjustments to the rate cells. During the following year, MCOs received another three percent (3%) increase to all rate cells with a total of a five percent (5%) increase to the rate cell for TennCare/Medicare enrollees. Additionally, a retroactive two percent (2%) increase was applied as a one time adjustment to the rates for the period July 1, 1998 through June 30, 1999. These rate increases have been applied uniformly to all MCOs in the TennCare program.

In the fall of 1998, the State Comptroller commissioned a report by the consulting company Price Waterhouse Coopers to evaluate the state's capitation payments. In March of 1999, PWC representatives presented their finding to the legislature, which included concerns about the efficiency of payments made by MCOs to their providers. The PWC report recommended an increase in the capitation rate, and the Bureau added sixteen dollars ($16.00) to

every rate cell for the period beginning July 1, 1999. Because the increase had been made in order to improve the compensation to providers for medical services, the Bureau instructed all MCOs that at least twelve dollars, forty cents ($12.40) of the sixteen dollars ($16.00) increase had to be applied toward "new money" for providers and could not be used to address increased in utilization. Limiting the twelve dollars, forty cents ($12.40) portion of the increase to new provider payments meant that no more than three dollars and sixty cents ($3.60) of the increase could be retained for profit, used to pay administrative fees, or used to satisfy any existing provider debt. Although TCCN and the other MCOs were prohibited from applying any of the twelve dollar, forty cents ($12.40) portion to curing existing net worth deficiencies, the plans could, and some did, apply portions of the remaining three dollar, sixty cents ($3.60), more than twenty percent (20%) of the total increase, for this purpose.

The restriction on the use of the twelve dollars, forty cents ($12.40) portion of the rate increase applied equally to all TennCare MCOs. Each MCO was required to submit a spending plan, known as a "twelve dollar, forty cent ($12.40) plan" for approval by the TennCare Bureau before the new funds would be released. The Bureau contracted with PWC to review all spending plans prior to approval and to monitor each MCO's compliance with its approved spending plan.

All MCOs, except Xantus, which had entered voluntary rehabilitation, also received the benefit of the one-time retroactive two percent (2%) capitation rate increase for the period July 1, 1998 to June 30, 1999. To ensure that this extraordinary measure would be used to improve the financial viability of the MCOs, the TennCare Bureau imposed certain conditions on the use of these funds. Among the restrictions, applied to all MCOs, was that none of the payment be used for management fees. The MCOs also agreed to waive any challenges to the adverse selection payment methodology used during the period from January 1, 1994, to January 30, 1999.

In 2001, the TennCare implemented the further changes to its capitation and adverse selection payment methodologies.

TCCN provides a health plan known as Access. . . Medplus to TennCare enrollees throughout the state. Before TennCare, TCCN was known as TMCN and operated the state's first and only Medicaid HMO, providing health care to approximately thirty thousand (30,000) enrollees. After it contracted with the state to participate in the TennCare program it aggressively advertised the Access. . . Medplus plan to increase its enrollment. As a result, it

grew from an approximately thirty thousand (30,000) member plan to a more than two hundred, fifty thousand (250,000) member plan within its first year in the TennCare program. Almost immediately, TCCN began to experience problems in performing under the terms of its Contractor Risk Agreement. As reflected in the August 3, 1995 financial and compliance audit report of TCCN issued by the Comptroller of the State Treasury for TCCN's first year of TennCare operation, TCCN had several deficiencies in its operations. These deficiencies included understatement of liabilities and overstatement of assets, weaknesses in claims processing operations, which resulted in a backlog of unprocessed provider claims, and weaknesses in management oversight and internal controls. An onsite examination of TCCN in 1995 identified a statutory net worth deficiency of five million, eight hundred thousand dollars ($5,800,000.00) as of August 31, 1995, subsequently adjusted downward to approximately four million, eight hundred thousand dollars ($4,800,00.00). The Tennessee Department of Commerce and Insurance directed TCCN to make a capital infusion of at least four million, eight hundred thousand dollars ($4,800,000.00) to cure the deficiency.

Around the same time, TCCN underwent a series of operational modifications, including an asset purchase agreement between TCCN and a management company, Medical Care Management Company (MCMC) as well as execution of a management agreement between MCMC and TCCN to perform all of the services of operating Access. . . Medplus, including maintaining its claims processing system and filing the required financial statements. Most of TCCN's employees went to work with MCMC, and TCCN then had only one employee, its President Al Head. TCCN and MCMC shared board members and are located in the same office building. The ultimate parent company of MCMC, Access Health Systems, Inc., provides management staff services as well as system support to MCMC in a performance of its management contract. Under the contract, MCMC also has agreed to conduct marketing activities. Until recently, MCMC received approximately five million dollars ($5,000,000.00) per month for those services, roughly ten percent (10%) of TCCN's approximately fifty million dollars ($50,000,000.00) monthly capitation payment from the state. Due to a substantial drop in enrollment in the last open enrollment season, TCCN's capitation rate now is approximately forty-one million dollars ($41,000,000.00) per month, of which MCMC receives approximately ten/eleven percent.

After the transfer and contract with MCMC, TCCN operated its plans without apparent net worth problems for the next two years. The Division scheduled TCCN for a standard examination in August of 1998, which TCCN asked the Division to reschedule, so as to avoid delay in implementing its new claims processing system. Before the examination could be rescheduled, and before the new claims processing system was implemented, representatives of MCMC and AHS, acting on TCCN, behalf, approached the Division in May of 1999, to report a serious statutory net worth deficiency, allegedly caused by the combined effects of the change in adverse selection rates and an approximately nine million dollar ($9,000,000.000 increase in IBNR liabilities estimated by TCCN's actuary. With the advice and consent of counsel, TCCN entered into an agreed order of supervision beginning on June 14, 1999, and Elizabeth Baldwin was appointed as the supervisor. Under the terms of the agreed plan, TCCN was required to submit a corrective action plan.

During this same time, the Tennessee Legislature approved the sixteen dollars ($16.00) per member per month capitation rate increase, effective July 1, 1999. The infusion of an additional sixteen million dollars ($16,000,000.00) into the adverse selection fund, a large portion of which went to TCCN, and the one-time retroactive two percent (2%) capitation rate increase represented initiatives by the state that should had led to substantial improvement in TCCN's financial position. Due to the need to more quickly resolve its net worth deficiency, TCCN agreed to the further restriction, as a condition of its voluntary supervision, that no portion of the three dollars and sixty cents ($3.60) could be used to implement its management fees to MCMC. After TCCN reported that the deficiency was cured as of November 30, 1999, MCMC began receiving its percentage of the three dollar, sixty cent ($3.60) increase.

Upon receipt from TCCN of report showing that its net worth deficiency had been resolved, the Division terminated its agreed order of supervision of TCCN, as of February 3, 2000. The examination of TCCN continued, however, and letters of examination were agreed upon by TCCN and its counsel on February 3, 2000 and March 6, 2000 because of substantial problems with TCCN's claims processing system that began immediately after the much-delayed implementation of its new claims processing system on or about December 17, 1999.

In response to increased complaints from providers on late and inaccurate payments from TCCN, the Division first conducted onsite investigations and then commissioned Peterson Worldwide, LLC Consultants to investigate the timeliness and accuracy of TCCN's claim

processing system. Peterson's reports on the claims system revealed significant deviation from the statutory and contractual timeliness requirements and unacceptable error rates. Concerned by reports from Peterson that a large percentage of TCCN's provider claims were unaccounted for, the Division commissioned the Mercer Consulting Company to investigate TCCN's operation processes through on-site reviews. Based on its original on-site reviews in February and March of 2000, Mercer produced a report dated April 6, 2000. Specifically, Mercer found that TCCN was experiencing major problems in achieving timely and accurate claims payments since the conversion of its claim system in December of 1999, which TCCN's management itself has admitted. Mercer also found that TCCN was suffering from major deficiencies in its claims reporting. The TennCare Division agreed with Mercer's finding that TCCN's claims processing problems were a direct result of the conversion of MCMC's claim system, as well as its failure to adequately plan and budget staff resources for the conversion.

TCCN continued to make inaccurate and untimely payments to providers. Based on a variety of sources, including admissions by current management, it was apparent that the current claims processing system was demonstrably inadequate and operating with numerous errors and inaccuracies in payment. TCCN's management announced that its new claims processing system would be fully operation as of May 1, 2001. That deadline was not met and those problems continued.

The substantial shortcomings of TCCN's claims processing problems also caused the Division to question TCCN's net worth. As a result of its non-functioning claims system, TCCN began to make "advanced payments" to its providers, that is payments in advance of services. If the paid provider stops treating a patient or is overpaid, the MCO is forced to seek a recoupment from the provider causing further expense and delay. Advance payments act as a warning sign to regulators. Once a receivable due from an incorrectly paid advanced payment is due more than ninety days (90), it can no longer be counted as an admitted asset. With an inadequate claims processing system, the likelihood of recouping any claimed over payments within ninety days (90) is significantly decreased. The Division's own calculations of TCCN's assets and liabilities in 2000 suggested that TCCN had a deficient and, most likely negative net worth.

Concerned by the protracted delays in TCCN's provider payments, complaints from providers, some of whom were leaving TCCN's network or initiating litigation against TCCN, and an inability to evaluate TCCN's net worth, the State filed a petition for rehabilitation of

TCCN in order to protect the company, providers and enrollees. Based on assurances by TCCN that its latest claims processing system would end the then current problems on May 1, 2001, the Chancery Court denied the State's petition. The May 1, 2001, deadline was not met, and on information and belief, TCCN was still unable to make sufficiently, timely and accurate provider payments. TCCN was unable to demonstrate its net worth or approach in adequate claims timeliness or accuracy level. It continued the supervision by agreement, extended on June 26, 2001, to be effective until March 1, 2002.

In their discussion of the law, relating to the circumstances, the state defendants contend that suit based upon the Equal Access Claim, alleged to be founded within 42 U.S.C. §1396a(a)(30)(A) via 42 U.S.C. §1983, is barred by issue preclusion. After the repeal of the Boren Amendment, there have been no decisions noting a right of action. The decision in *Evergreen Presbyterian Ministries v. Hood* from the Fifth Circuit was cited. 235 F.3d 908, 928-929 (5th Cir. 2000). United States District Court Judge Todd J. Campbell had concluded that an MCO has no right of action under the Equal Access Clause and dismissed this claim by TCCN by order of April 26, 2001 in the case of *Tennessee Coordinated Care Network v. Neel*, Case No. 00-1226 (M.D. Tenn.). This ruling binds TCCN in this cause.

The state defendants contend that as to the claim of intentional discrimination under 42 U.S.C. §1981 or Title VI, the undisputed facts, established through the affidavits of Martins, Tighe and Newton do not support such claims. A cause of action under 42 U.S.C. §1981 requires proof of intentional discrimination. Section 601 of Title VI creates a federal cause of action, which like §1981 requires proof of intentional discrimination. Under section 602 of Title VI, federal agencies are instructed to promulgate regulations designed to "perfectuate the provisions" of Title VI and are responsible for tracking compliance. Agencies are authorized to withhold funding as a penalty for non-compliance. The Department of Health and Human Services, the agency responsible for Title VI regulations in the Medicaid context, issued regulations at 42 C.F.R. Part 80. Although the HHS regulation purports to impose a disparate impact standard, the Supreme Court recently held that Title VI regulations do not create a private right of action. *Alexander v. Sandoval*, 121 S. Ct. 1511, 1523 (2001). Accordingly, TCCN cannot make a claim for discrimination under a disparate impact theory under Title VI regulations. Its claim must be based upon proof of intentional discrimination by the State. The

states defendants contend that the factual premises, established in the affidavits, prove that such a case cannot be made.

The state defendants contend that TCCN identifies no facts which suggest that the challenged actions were in fact motivated by racial discrimination. In order to establish a claim of intentional discrimination, TCCN must prove that: (1) defendants treated similarly situated minority owned and operated MCOs differently than non-minority owned and operated MCOs and (2) defendants were motivated in doing so on the basis of race. *Shah v. General Electric Company*, 816 F. 2d 264, 270-271 (6th Cir. 1987) (citing *Reynolds v. Humko Products*, 756 F. 2d 469-472 (6th Cir. 1985)). The Supreme Court has identified several factors that may established a racially discriminatory intent behind a facially neutral decision, (1) racial impact; (2) historical background; (3) events preceding the decision, including any departures from standard procedures; and (4) any legislative or administrative history. See *Village of Arlington Heights v. Metropolitan Housing Development Corporation*, 429 U.S. 252, 97 S.Ct. 555 (1977). But, the sine qua non of a discrimination claim remains a showing of different treatment.

The state defendants contend that the attempts of TCCN to establish a claim of intentional discrimination failed for two main reasons. The first of these is that most of the actions cited in TCCN's complaint have been applied uniformly to all TennCare MCOs and thus fail to make the required showing of different treatment. Secondly, even in those few instances where TCCN or another MCO has been treated differently, there is no evidence that the defendants were ever racially motivated in any of these instances, or in any aspect of their administration of the TennCare program. TCCN cannot point to a single instance in which it was treated differently in such a way that would support a reasonable inference of intentional discrimination. Underlying each instance of different treatment is a legitimate, non-pretextual and race-neutral decision by the defendants, necessitated by circumstances that did not apply equally to all MCOs.

As to instances identified by TCCN concerning: (1) contract negotiations between TennCare and the MCOs; (2) restrictions on the use of the sixteen dollars ($16.00) per member per month capitation rate increase in 1999; (3) the retroactive change in the adverse selection rate in 1998; (4) the change in its adverse selection enrollment in 2000; (5) restrictions on the use of the retroactive two percent (2%) capitation rate increase in 1999; and (6) examination and supervision of TCCN, the state defendants contend that the affidavits supporting their motion

establish that most of these instances are not evidence of differential treatment and none support an inference of discriminatory treatment based upon race.

As to contract negotiations, the Bureau has negotiated the exact same contract, the exact same amendments, with all MCOs in the program throughout the period covered by the complaint. After the PPOs converted to HMO status, all TennCare MCOs operated under an identical contract. The two occasions of altered relationship with the state involve Xantus in voluntary rehabilitation and the circumstances for exercise of the exigency clause in connection with VSHP and John Deere.

As to TCCN's challenge for the change in capitation rates that occurred in 1999, the TennCare Bureau changed its capitation rates in 1999 in response to an independent, objective study that raised concerns about the adequacy of payments from MCOs to their providers. Based on the recommendations of that report, the Legislature approved a sixteen dollar ($16.00) per member per month increase in the capitation rate, which the Bureau applied to every reimbursement rate cell. When the capitation rate was modified, all MCOs received the same change in rate. There were two types of restrictions placed on TCCN's use of its sixteen dollar ($16.00) increase. One was that which applied to all TennCare MCOs, which was that twelve dollars and forty cents ($12.40) of the sixteen dollars ($16.00) was to be committed for the sole purpose of new provider payments. The other, under which MCMC voluntarily waived its contractual right to receive a portion of the increased capitation rate as a further management fee until TCCN corrected its statutory net worth deficiency, was agreed to by MCMC with the advice and consent of its counsel. This restriction would not have occurred had TCCN been able to maintain an adequate net worth, and creates no inference of racial animus. The restriction was lifted, as soon as the division was able to verify that TCCN could satisfactorily demonstrate its statutory minimum net worth.

As to the contention by TCCN that it was discriminated against when the TennCare Bureau retroactively adjusted the adverse selection rates in 1999, this change applied equally to all MCOs and was based on the recommendation of an independent consultant. TCCN and other MCOs were substantially impacted. Two changes in payment rates, implemented at the same time, substantially offset the impact. The TennCare Bureau infused an extra thirteen million, four hundred thousand dollars ($13,400,000.00) into the forty million dollars ($40,000,000.00) adverse selection pool of funds during the first year of the new adverse selection rate. This

infusion had the effect of offsetting virtually all of TCCN's reimbursement obligations to the State, and TCCN received a greater benefit from this infusion than any other MCO. Further, the TennCare Bureau funded a one-time two percent (2%) retro-active capitation rate increase. The nature and timing of these two actions, which so substantially benefited TCCN, demonstrate the lack of merit to any assertion that any aspect of the TennCare program's operation was motivated by racial animus.

TCCN asserts that its adverse selection population was intentionally increased. The state defendants respond that through the period covered by the complaints of TCCN, enrollees were assigned neutrally to all MCOs. In the year 2000, TCCN was the only statewide MCO accepting new enrollees and TCCN may suggest that it received a disproportionate number of adverse patients at that time. However, this does not permit an inference of discrimination. VHSP was contractually prohibited from accepting new enrollees in 2000, and Xantus had already entered a voluntary rehabilitation, which foreclosed further enrollment. Those conditions were not created to discriminate against TCCN or to harm the other MCOs that received additional enrollees during that period.

As to the contention of discrimination in the restrictions placed on the one-time retroactive two percent (2%) capitation rate increase in 1999, all but one of the TennCare MCOs used management contracts to administer all or part of their obligations under the TennCare contracts. The two percent (2%) retroactive increase was an unusual step to benefit the MCOs and was implemented at a time when certain MCOs, particularly TCCN, were being affected by changes in the adverse selection methodology. This step was intended to benefit, not to discriminate against TCCN. The limit of the use of the new funds was to ensure that the money would be used to help MCOs rather than their management companies. TCCN was treated no differently than any other MCO in its ability to use the two percent (2%) increase, of which TCCN was a principal beneficiary.

TCCN appears to be challenging every regulatory decision involving TCCN made by the TennCare Division of the Tennessee Department of Commerce and Insurance since 1995. The Division has the authority and obligation to regulate and oversee the MCOs participating in the TennCare program. Under the Tennessee HMO Act and the Insurer's Rehabilitation and Liquidation Act, the Division has considerable discretion in carrying out its responsibility to protect the interest of the patients, providers and shareholders of the TennCare MCOs. MCOs

must comply with statutory and contractual net worth and prompt pay requirements. TCCN frequently failed to meet those requirements, most notably within the last three years.

The history of non-compliance by TCCN with net worth and prompt pay requirements began almost immediately after it expanded its enrollment ten fold at the inception of the TennCare program. By the end of the first year, it had a net worth deficiency and was unable to pay its providers on time without the use of advance payments. Although it temporarily cured its net worth problems with an infusion of capital in 1996, by September of 1998, representatives of MCMC and AHS, acting on TCCN's behalf, approached the Division to advise them of another serious net worth deficiency. With the advice and consent of counsel, TCCN entered into an agreed order of supervision beginning on June 14, 1999. When TCCN demonstrated that it had cured that net worth deficiency, the agreed order of supervision was terminated on February 3, 2000.

Although TCCN appeared to have again cured its net worth deficiency, that problem was supplanted by the disruption in the claims payments caused by TCCN's conversion to a new claims processing system on or about December 17, 1999. The Division investigated the frequent complaints it began receiving from providers about untimely or inaccurate payments from TCCN. As a result of the problems discovered during this investigation, the Tennessee Department of Commerce and Insurance entered into a letter of examination with TCCN on February 3, 2000, which permitted TDCI direct access to the TCCN claims processing facilities and systems. The February 3, 2000, letter of examination was signed by TCCN's counsel.

Subsequent on-site visits by TDCI and two independent consultants revealed serious inadequacies in TCCN's claims handling, evidenced by TCCN's payment of more than twenty million dollars ($20,000,000.00) in advanced payments to providers in the first two months after conversion to its new claims processing systems. These on-site visits made it apparent that the February 3, 2000, letter of examination did not give the Division sufficient access to monitor the claims processing system, so TCCN and the Division entered into an enhanced letter of examination on March 6, 2000, which was also signed by counsel for TCCN.

An inability to promptly and accurately pay providers not only undermines the State's ability to evaluate the net worth of the MCO, but also threatens the stability of the provider network, if providers terminate their contracts with the MCOs as a result of late and inaccurate payments. The latter concern troubled the Division because TCCN served twenty-five percent

(25%) of the TennCare population. In the opinion of TDCI, deficient or negative statutory net worth problems for TCCN continued. Problems with accurate and timely provider payments persisted. For those reasons, it remained under a continuous period of agreed supervision, extended June 26, 2001 through March 1, 2002.

Against this backdrop, the state defendants contend that the contention that the State's actions were pretextual is baseless. The fact that TCCN agreed to all of the letters of examination and all but one of the orders of supervision and admitted its inability to comply with the requirements it agreed to meet in those letters, belies TCCN's post hoc effort to impugn the State's regulatory actions as racially discriminatory.

The states defendants contend that the efforts of the State demonstrate an ongoing effort to get and keep TCCN in the program in the face of its continuing inadequate performance. Those responsible for creating the TennCare program wanted TCCN's participation at the program's inception because it had some experience in providing managed care in the former Medicaid program and various state officials took steps that help TCCN stay in the program, such as rate increases that helped offset the impact of the change in adverse selection policies and repeated extensions to a TCCN's attempts to comply with its statutory and contractual requirements. Had the state wanted TCCN out of the program, it could have exercised its right of termination in the contract.

The state defendants contend that they are entitled to summary judgment on Count IV, which is premised upon the Fourteenth Amendment to the United States Constitution and Article I, Section 21 of the Tennessee Constitution. TCCN has failed to allege any facts to support these due process claims. TCCN has not explained whether the claim is for a deprivation of substantive or procedural due process. It does not state any protected interest of which it was deprived or any process to which it was due or denied. Conclusionary allegations are insufficient. *Blackburn v. Fisk University*, 443 F. 2d 121, 124 (6th Cir. 1971) no protected property or liberty interest is specifically alleged.

THE TENNCARE CONTRACT WITH TCCN (TMCN)

The initial agreement was executed between the State of Tennessee and Tennessee Managed Care Network d/b/a Access. . . MedPlus. Anthony Cebrun, Chief Executive Officer for Tennessee Managed Care Network, Inc., signed the agreement on November 29, 1993. Representatives of the state signed on the same date.

The agreement begins with a statement of the purpose of the agreement being to assure Tennesseans of quality healthcare services while controlling the cost of such healthcare services. Waivers had been granted to permit Tennessee the authority to pay a monthly prepaid capitated payment. The agreement sets out in great detail the obligations and responsibilities of the contractor various non-covered services were identified. The contractor agreed to accept a reasonable number of enrollees, from any plan in the contractor service area which might become insolvent. Agreement, p. 19. Enrollees were given their choice of health plans, if more than one plan was available in a community service area. The contractors were permitted to market their services.

The contractor agreed to accept the capitation payments that TennCare would remit to the contractor which are equal to the number of enrollees in each TennCare enrollee category multiplied by the pro-rated capitation rate established for each group. Agreement, at p. 37.

The agreement provided that TennCare shall be responsible for management of the agreement and that management shall be conducted in good faith with the best interest of the state and the citizens it serves being the prime consideration. Agreement, p. 50.

Section 3-10 of the agreement provides for the establishment and payment of the capitation rate. The agreement began with a statewide average capitation rate for each covered enrollee category. The agreement provided that it was anticipated that in the future TennCare will contract with each contractor based upon a capitation rate for a community for the provision of services to any enrollee in that community. Times for payment and enrollee categories were specifically set out, as well as the rates for such categories. Agreement, p. 52-56.

The contract includes a provision for liquidated provisions. The contractor is liable to TennCare for liquidated damages in the amount of one hundred dollars ($100.00) per work day per report or deliverable. As for disputes, Section 4-18 provides that the contractor agrees that

the contractor shall give notice to TennCare of its claim thirty calendar days prior to filing the claim in accordance with T.C.A. §9-8-301 et seq.

In Section 4-23, the parties acknowledge that the contractor is licensed to operate as a health maintenance organization in the State of Tennessee and is subject to regulation supervision by the Tennessee Department of Commerce and Insurance. The parties acknowledge that no action by TDCI to regulate the activities of the contractor shall constitute a breach of the agreement by TennCare.

In Amendment 3, the parties agreed among other things, to a restatement of monthly capitation rates and that capitation rates described in Section 3-10.v. of the agreement may be increased periodically. This agreement was executed on March 28, 1995. The same section was amended again in agreement 6, executed May 25, 1995.

The parties executed another Contractor Risk Agreement on September 27, 1995. The comprehensive agreement included specific provisions for the payment of the capitation rate on a statewide average basis for each covered enrollee category. Subsequent amendments addressed various issues, including the capitation rates. The parties executed an amended and restated Contractor Risk Agreement in July of 2001. It provided in detail for the manner and means of payment to the contractor, described in Section 3-10, including the option of the risk banding choices. Section 4-22 provided that the capitation rates described in Section 3-10 may increase periodically. In the event of significant change, as mandated by actions of Congress, the State Legislature or others, the Bureau of TennCare shall review and adjust capitation accordingly subject to the availability of state appropriations for the mandate.

AN INDEPENDENT RISK SELECTION STUDY

The TennCare Program became the subject of various research studies, along with similar programs in Hawaii, Maryland, Oklahoma and Rhode Island. One of those studies resulted in the paper titled *"Is Risk Selection Among Nondisabled Enrollees in TennCare a Thing of the Past?"* authored by Cheri Vogel and Lorenzo Moreno. Their research was funded by the Health Care Financing Administration, the Office of the Assistant Secretary for Planning and Evaluation and the Substance Abuse and Mental Health Services Administration. The report is dated April 27, 2001. It was prepared during a six year evaluation of these programs.

The authors noted that others had written of the existence of risk selection across MCO's in TennCare. Risk selection arises for many reasons. Marketing practices, provider networks and reputations can differ. At the outset of TennCare, 60% of the enrollees selected their own MCO and the rest were distributed by the State by the percentage of active selection. An unintended effect of this may be to concentrate high-need beneficiaries in a few MCO's if their providers are similarly concentrated in them.

Assessment is complicated by regional differences in Medicaid expenditures. TennCare has 12 service regions, 4 urban and 8 rural. Medicaid expenditures in the state's northeastern service regions tend to be much higher that in the southwestern ones.

The study focused upon 225,229 TennCare beneficiaries, who were enrolled in Medicaid for all of 1993 and who were enrolled in one of the TennCare MCO's in October 1994, January 1995 and January 1996. Excluded were blind and disabled beneficiaries, anyone dually eligible for Medicare before 1996 and anyone older than 64 years of age in 1996. Thirty percent of the enrollees were Access MedPlus participants, as of October 1994. Forty one percent were with BCBS. The authors also used encounter data for the period 1996 through 1997 to provide an alternative picture of risk selection in subsequent years of TennCare.

Risk selection indices based on 1993 expenditures across MCO membership in October 1994 suggest that HealthNet, PHP, TennSource, Total Health Plus, and Phoenix (later Xantus) had adverse selection. OmniCare, TLC and Prudential had favorable selection and the rest (including Access MedPlus) hovered near the break-even point. The pattern of risk selection for this continuous sample did not change substantially from October 1994 through January 1996. The only two MCO's to experience worsening selection over time were BCBS and Prudential. Selection for Access MedPlus declined slightly, according to the authors.

In their summary table of selection across samples and studies, Access MedPlus ranked 10th out of twelve, with twelve being the most favorable selection. Tops on the list was HealthNet. BCBS was sixth and Phoenix (later Xantus) was ninth. Phoenix/Xantus acquired HealthNet in December 1997.

PERTINENT LEGAL AUTHORITIES

Shah v. General Electric Company, 816 F.2d 264 (6th Cir. 1987) – In this suit, the plaintiff brought an action against his employer for discriminatory termination of his employment because of his color and national origin in violation of Title VII and 42 U.S.C. §1981. He also alleged breach of an implied contract of employment. United States District Court for the Western District of Kentucky granted summary judgment in favor of the employee defendant. The 6th Circuit Court of Appeals found that the plaintiff failed to establish a prima facie case of discriminatory discharge where his vacated position was not filled and there was no evidence that other employees were similarly situated. In a disparate treatment case, the plaintiff's ultimate burden is to persuade the court that he has been the victim of intentional discrimination. The plaintiff must prove a prima facie case; the defendant must offer a legitimate, non-discriminatory reason for its action; and the plaintiff must establish that the defendant's proffered explanation is a pretext to mask an illegal motive. *McDonnell Douglas Corporation. v. Green*, 411 U.S. 792, 802-04, 93 S.Ct. 1871 (1973). The prima facie case presents an inference of discrimination. The central inquiry in evaluating whether the plaintiff has met his initial burden is whether the circumstantial evidence presented is sufficient to create an inference of discrimination.

Wilder v. Virginia Hospital Association, 496 U.S. 498, 110 S.Ct. 2510, (1990) - Virginia Hospital Association filed an action against state officials under 42 U.S.C. §1983, alleging that the rates for the state's plan for reimbursing health care providers were not reasonable and adequate to meet the cost of the Medicaid scheme in the State of Virginia. Motions for summary judgment and dismissal were denied below. The state and its officials appealed to the United States Supreme Court.

The state contended that 42 U.S.C. §1983 did not afford the hospital management a cause of action to challenge the state's compliance with the Medicaid Act, because the act did not create any enforceable rights and Congress had foreclosed its enforcement under §1983. The Court held that §1983 created enforceable rights because the Act was intended to benefit the hospital management. It held that the state was obligated to adopt reasonable and adequate rates and that this obligation was enforceable. The state failed to meet its burden in asserting that

Congress intended to preclude reliance on the statute, as a remedy for the deprivation of the federally secured right.

In 1980, Congress passed the Boren Amendment to the Medicaid Act, which required provider reimbursement according to rates that the "state finds, and make assurances satisfactory to the Secretary," are "reasonable and adequate" to meet the costs of efficiently and economically operated facilities." The state must also assure the Secretary that individuals have "reasonable access" to facilities of "adequate quality."

A plaintiff alleging a violation of a federal statute will be permitted to sue under §1983 unless: (1) the statute does not create enforceable rights, privileges or immunities within the meaning of §1983; or (2) Congress has foreclosed such enforcement of the statute in the enactment itself. *Wright v. Roanoke Redevelopment and Housing Authority*, 479 U.S. 418, 423 (1987). §1983 speaks in terms of rights, privileges or immunities and not violations of federal law. *Golden State Transit Corp. v. Los Angeles*, 493 U.S. 103, 110 S.Ct. 444 (1989). It must be determined whether the Boren Amendment created a "federal right" that is enforceable under 1983. The inquiry turns on whether the provision in question was intended to benefit the putative plaintiff. If so, the provision creates an enforceable right unless it reflects merely a "Congressional preference" for a certain kind of conduct rather than a binding obligation on the government unit. *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1, 19, 101 S.Ct. 1531 (1981). There will be no enforceable federal right if the inference the plaintiff asserts is too vague and amorphous, that it is beyond the competence of the judiciary to enforce. *Golden State*, supra.

In the five to four decision of the Court, it was concluded that the Medicaid Act created a right enforceable by health care providers under §1983 to the adoption of reimbursement rates that are reasonable and adequate to meet the costs of an efficiently and economically operated facility that provides care to Medicaid patients. The right is not merely a procedural one that rates be accompanied by findings and assurances of reasonableness and adequacy. Rather, the Act provides a substantive right to reasonable and adequate rates as well. From the decisions in *Pennhurst* and *Wright*, the majority concluded that the Boren Amendment imposed a binding obligation on states participating in the Medicaid Program to adopt reasonable and adequate rates and that this obligation is enforceable under §1983 by healthcare providers. The Court noted that prior to the passage of the Boren Amendment, Congress intended that healthcare providers be

able to sue in federal court for injunctive relief to ensure that they were reimbursed according to reasonable rates. For a period of time, Congress amended the Medicaid Act to require states to waive any Eleventh Amendment immunity from suit for violations of the Act. The states opposed this provision and it was repealed in the next session of Congress. Thereafter, prospective, injunctive relief could be pursued. The remarks of one of the Congressman are recorded in footnote 15 to state "although the provider can sue the state to enjoin action, they cannot sue to recover "lost funds" because of the immunity suit afforded states by the Eleventh Amendment."

Chief Justice Rehnquist authored the dissent. He noted that in §1983 actions to follow from the course created by the majority, court orders entered in such actions will require the states to adopt reimbursement rate systems different from those Congress expressly required them to adopt, based upon the language of the Boren Amendment to the Medicaid Act. The text of the Boren Amendment does not clearly confer any substantive rights on Medicaid services providers. Even if one were to assume a conferring of a substantive right, the statute placed its own limitation on the right in very plain language. The majority should not have looked beyond the unambiguous terms of the statute and relied upon policy considerations purportedly derived from the legislative history and superceded versions of the statute.

Suter v. Artist M., 503 U.S. 347, 112 S.Ct. 1360 (1992) – This suit was brought against the Director and Guardianship Administrator of the Illinois Department of Children and Family Services, to enforce the "reasonable efforts" clause of the Adoption Assistance and Child Welfare Act of 1980, at 42 U.S.C §620-628, 670-679a. This suit was brought under the Act and 42 U.S.C. §1983. The lower courts held that the Act contained an implied right of action, and that the respondents could enforce the Act through a §1983 action. The Supreme Court disagreed, holding that Congress did not unambiguously confer upon child beneficiaries, a right to enforce the requirement that the state make "reasonable efforts" to prevent a child from being removed from his home, and once removed, to reunify the child with his family. How the state was to comply with the "reasonable efforts" clause was, within broad limits, left up to the state. The term "reasonable efforts" in the context of the Act was to be read to impose only a rather generalized duty on the state, to be enforced not by private individuals, but by the Secretary of Health and Human Services.

Below, the District Court and the Court of Appeals for the 7th Circuit found that the statute contained an implied right of action and that the respondents could accordingly enforce that section of the Act through an action brought under §1983. The decisions below relied upon the decision in

Wilder v. Virginia Hospital Association. The Court of Appeals held that the reasonable efforts clause of the Adoption Act could be enforced through an action under §1983. The Court of Appeals applied the standard established in *Cort v. Ash*, 422 U.S. 66, 95 S.Ct. 2080 (1975) and found that the Adoption Act created an implied right of action such that private individuals could bring suit directly under the Act to enforce the provisions relied upon by the respondents.

The opinion was authored by Chief Justice Rehnquist for a seven justice majority. Justice Rehnquist noted that in the *Wilder* decision, the Court held that the Boren Amendment actually required the states to adopt reasonable and adequate rates, and that this obligation was enforceable by the providers. He noted that the Court relied in part on the fact that the statute and regulations set forth in some detail the factors to be considered in determining the methods for calculating rates. In the present case, the term "reasonable efforts" appeared in a different context with no further statutory guidance as to how "reasonable efforts" would be measured. After careful examination of the language relied upon by the respondents, in the context of the entire Act, it was concluded that the "reasonable efforts" language does not unambiguously confer an enforceable right upon the Act's beneficiaries. The term "reasonable efforts" in this context is at least as possibly read to impose only a rather generalized duty on the State, to be enforced not by private individuals, but by the Secretary in the manner discussed within the opinion. As to an implied right of action for private enforcement, under the test in *Cort v. Ash*, the burden is on the respondents to demonstrate that Congress intended to make a private remedy available to enforce the "reasonable efforts" clause of the Adoption Act. The most important inquiry is whether Congress intended to create the private remedy sought by the plaintiffs and the Court found that it did not.

Justice Blackman authored the dissent with Justice Stevens joining. Justice Blackman stated that the Court's conclusion is plainly inconsistent with the court's decision in *Wilder*. In the dissent, it was indicated that the Court had failed, without explanation, to apply the framework of precedent consistently deemed applicable and has supported its conclusion by resurrecting arguments decisively rejected two years prior in *Wilder*.

Wood v. Tomkins, 33 F.3d 600 (6th Cir. (Ohio) 1994) – Applicants for a Medicaid Home Care Waiver brought an action against the Director of the Ohio Department of Human Services, alleging that the director's administration of the home care waiver program violated various provisions of the Medicaid Act. The plaintiffs were service recipients, suing on behalf of their minor son. The program was referred to as the Medically Fragile Waiver Program. The question on appeal was whether the plaintiffs had a private right of action under 42 U.S.C. §1983 for the alleged Medicaid Act violations in light of the holding of the Supreme Court in the case of *Suter v. Artist M.*, supra.

The particular provision of the Medicaid Act allowed participating states to apply to the Secretary of HHS for a waiver of various requirements, in order that Medicaid funds might be used to provide home and community-based health services for individuals, who but for the wavier, would require institutional care. The provision included requirements upon the Secretary and the State. The State could not obtain a waiver unless it provided "assurances satisfactory the Secretary" that its waiver plan includes "necessary safe guards . . . to protect the health and welfare of individuals" receiving home care. Once a waiver is granted, the Secretary is required to monitor the implementation of the waiver program to ensure that all of the requirements are being met, and to terminate any non-complying waiver. The State of Ohio applied for its waiver and as a result the "medically fragile waiver" program was created. The Woods family applied for a medically fragile waiver, in connection with the health circumstances of their child. The director responded that the child would not be entered into the waiver program because they would not accept the number of hours of skilled nursing services approved by the program. An administrative hearing ensued. A statewide cap on the number of nursing services per day was established by the director. The Woods contended that this cap was not based on any sort of evaluation of the medical needs of the individual waiver program recipients. It put all of the waiver program recipients at risk and as implemented, violated several provisions of the Medicaid Act and the regulations that promulgated thereunder.

The District Court focused upon two statutory and two regulatory provisions and held that they created one or more rights that were actionable under §1983. That became the issue on appeal.

If the statute does not create an enforceable right, privilege or immunity within the meaning of §1983 or if Congress has foreclosed enforcement of the statute in the enactment

itself, a plaintiff may not pursue the violation of the federal statute under §1983. To assess whether an enforceable right has been created the three part test from the *Wilder* decision will be applied as follows:

(1) Was the provision in question intended to benefit the plaintiff?

(1) Does the statutory provision in question create binding obligations on the defendant governmental unit, rather than merely expressing a Congressional preference?

(2) Is the interest the plaintiff asserts specific enough to be enforced judicially, rather than being "vague and amorphous"?

As to foreclosure of enforcement by Congress within the Act, the only way Congress forecloses §1983 enforcement is by providing a comprehensive enforcement mechanism for protection of a federal right. Mere availability of administrative protections is not sufficient. Rather, the statutory framework must be such that allowing a plaintiff to bring a §1983 action would be inconsistent with Congress' carefully tailored scheme.

In the *Wilder* decision, the Court applied the test to the Boren Amendment and found that there was little doubt that healthcare providers were the intended beneficiaries of the Boren Amendment. Secondly, the Boren Amendment was cast in mandatory rather than precatory terms. Thirdly, although the amendment contained a flexible "reasonableness" standard, "the statute and regulation set out factors which a state must consider in adopting its rates," and "reasonableness" was to be measured "against the objective bench mark of an interior "efficiently and economically operated facility."" *Wilder*, at page 519. Consequently, even though "there may be a range of reasonable rates," the obligation to set rates that are reasonable was sufficiently particularized to be judicially enforceable. *Wilder*, at page 520. The Court found that the Medicaid Act's administrative remedy authorizing the Secretary of HHS to withhold approval of a state plan, or to cut off federal Medicaid funds, was not sufficiently comprehensive to foreclose a private right of action under §1983, Id. at 522-23.

In the subsequent decision in *Suter v. Artist M.,* the Court discussed whether a provision of the Adoption Assistance and Child Welfare Act of 1980 conferred a §1983 private right of action. The Court compared the circumstances of *Wilder* with the circumstances in *Suter* and found that in *Wilder*, the statute and regulations provided detailed factors to be used in determining rather rates were or were not "reasonable." In *Suter*, there was only an amorphous "generalized duty" imposed upon the state. Too much was left to the discretion of the

participating states to create an enforceable right in the context of the statutory and regulatory authority in the *Suter* case.

The Court of Appeals evaluated individual provisions of the Act at issue, along with corresponding regulation. In focusing upon the Act provision and regulation providing that a state may not spend more on home care than it would have spent on institutional care were the home care waiver unavailable, the Court found that these provisions failed the first prong of the *Wilder* test. They were not intended to benefit plaintiffs as Medicaid recipients. They were intended to save government money by eliminating the amount of Medicaid funds the state may spend on home care. As to the statutory provision requiring the Secretary to continue to monitor the state's waiver program, to assure that the requirements continue to be met and to terminate waivers for non-compliance, the statute placed the onus of compliance directly upon the Secretary, rather than the states. That does not create an enforceable right against the state. With reference to the regulation providing that a state must furnish HCFA with an explanation supporting documentation satisfactory to HCFA of how the agency estimated the per capita expenditures for services, the Court noted that the regulation makes it clear that its purpose is to limit the amount of money that a state may receive. Thus, the purpose of the regulation was not to benefit Medicaid recipients. No enforceable right would follow.

In *Wilder*, the Supreme Court held that the administrative remedy set forth in the Medicaid Act for violations under the Act cannot be considered sufficiently comprehensive to demonstrate a Congressional intent to withdraw the private remedy of §1983. 496 U.S. at 512. The Court of Appeals considered this holding dispositive, as the remedies described in *Wilder* are the same remedies set forth in the Medicaid Act for the alleged violations at issue.

In the dissenting opinion, the conclusion was that the challenged provisions of the Medicaid statute did not create rights enforceable in a private action by individual recipients. What the plaintiffs seek in the action is a judicial determination that their son is not receiving the amount of home-care to which they believe he is entitled. Nothing in the language of the relevant provisions of the Medicaid Act supports this position. The state is permitted to provide for part or all of the costs of home or community-based services. No provision of the code or regulation requires the State to defer to the demands of the particular recipient in determining how much care the state will provide pursuant to the plan.

Visiting Nurse Association of North Shore, Inc v. Bullen, 93 F.3d 997 (1st Cir. 1996) – This suit was filed by nine Massachusetts healthcare providers under 42 U.S.C. §1983, alleging substantive and procedural violations of the Medicaid Act at 42 U. S.C §1396a(a)(30), by various officials of the Massachusetts Medicaid program. The District Court granted partial summary judgment for the plaintiffs, declaring the defendants in noncompliance with certain procedural requirements relating to the establishment of reimbursement rates for healthcare services provided to Medicaid recipients.

A state which elects to participate in Medicaid is eligible to receive federal funds only if its state plan is approved by the Federal Healthcare Financing Administratio n. There are sixty-two (62) criteria for HCFA approval. One of those at 42 U.S.C. §1396a(a)(1)-(62) is referred to as the "Equal Access" clause. It provides that a state plan for medical assistance must provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in §1396b(i)(4) of the Title as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care, and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that care and services ar e available to the general population in the geographic area.

Massachusetts establishes its reimbursement rates through the Massachusetts Rate Setting Commission, with the approval of the Division of Medical Assistance of the Massachusetts Executive Office of Health and Human Services. Before 1991, Massachusetts used a cost based methodology for setting rates. In 1991, Massachusetts decided to convert to a class rate system with a single, fixed reimbursement rate for each of the five medical services cate gories, to be applied across the board to all in-state healthcare providers without regard to their individual costs. Under the Medicaid Act and Regulations, the state was required to submit the plan amendment to HCFA for approval and provide public notic e describing the proposed changes and an explanation for them. Public notices were provided. Public meetings occurred.

After the effective date for the new rates, the plaintiffs filed their §1983 suit alleging that the Commissioner and members of the Commission had violated various substantive and procedural requirements, prescribed by 42 U.S.C. §1396a(a)(30). They contended the public notices contain legally deficient descriptions by failing to disclose the formula used to arrive at

the interim, phase-in or final class rates. It was also alleged that the defendants failed to file an appropriate amendment to the Massachusetts plan, describing the material changes in the reimbursement rate methodology.

Massachusetts filed its plan amendment with HCFA. HCFA requested additional information. While this consideration was underway, the District Court granted partial summary judgment for the plaintiffs on their procedural claims, ruling that the public notices did not provide adequate detail on the proposed methods and procedures. The defendants issued another public notice with a detailed description of the methodology used to calculate the new final class rates and filed its second plan amendment with HCFA with the same level of detail as contained within the notice. HCFA approved the amendment, retroactive to January 1, 1994.

The District Court entered a final judgment reaffirming its prior finding of invalidity in connection with the initial notice and plan amendment requirements. It found compliance with respect to the subsequent notice. The Court ruled that the defendants never violated §1396a(a)(30) public notice and plan amendment requirements regarding the interim and phase-in rates, because they did not effect a "material" or "significant' change from the pre-1991 "cost-based" methods and procedures. The District Court dismissed the remaining claims of the plaintiff.

The Court of Appeals analyzed §1396a(a)(30) with the *Wilder* analysis. The Court noted that every court that has considered whether the *Wilder* rationale applies to the second "Equal Access" right described in §1396(a)(30) has determined that healthcare providers were intended beneficiaries under both the Boren Amendment and §1396a(a)(30), since healthcare providers, as payees, obviously are affected by substantive changes in state reimbursement schemes under Medicaid. See e.g. *Arkansas Medical Society, Inc. v. Reynolds*, 6 F.3d. 519, 528 (8th Cir. 1993); *Sobky v. Smoley*, 855 F. Supp. 1123, 1137-38 (ED. Cal. 1994); *Oklahoma Nursing Home Association v. Demps*, 792 F. Supp. 721, 727 (W.D. Okla. 1992); *Illinois Hospital Association v. Edgar*, 765 F. Supp. 1343, 1348-49 (N.D. Ill. 1991).

The Court noted that in the *Wilder* decision, the Boren Amendment made specific reference to hospital services, nursing facility services, etc. Although §1396a(a)(30) does not specifically make healthcare provider mention, this is not a distinguishable difference. As long as the two statutory provisions evince a Congressional concern for preserving financial

incentives to providers, by insuring adequate reimbursement payment levels, providers are appropriate considered intended beneficiaries. *Arkansas Medical Society, Inc*, 6 F.3d at 526.

The Court found that the Boren Amendment and §1396a(a)(30) are prefaced with the same mandatory language. The Boren Amendment and §1396a(a)(30) contain nearly identical substantive requirements that the rates, or methods and procedures, used to determine reimbursements to healthcare providers ultimately ensure reasonable, adequate or equal "access" to medical care. The Court in *Wilder* decided this was not too vague or amorphous a standard for judicial enforcement. The Court concluded that the plaintiffs have standing to enforce the substantive §1396a(a)(30) requirement that the state adopt "methods and procedures" which will afford "equal access" to medical care as defined in §1396a(a)(30). The Court found that the defendants were not in violation of the section's procedural requirements from January 1 to October 31, 1994.

The Methodist Hospitals, Inc. v. Sullivan, 91 F.3d 1026 (7th Cir. 1996) – Indiana changed its formulas used to pay providers of services under the Medicaid program on January 1, 1994. All of these formulas, with one exception, were replaced within a year. The new rules were contested on the basis of 42 U.S.C. §1983. The District Court dismissed, holding that the statute did not create a private right of action for the plaintiffs.

An issue on appeal was the contention of the plaintiffs that Indiana's rules did not comply with 42 U.S.C. §1396a(a)(30). The District Court dismissed the claim, premised on this section, after finding that the words "geographic area" were so ambulatory that the section did not create a private right of action. The Court of Appeals chose to follow the decision in *Arkansas Medical Society v. Reynolds*, 6 F.3d. 519 (8th Cir. 1993) and held that providers of medical care have a private right of action, derived from §1983 to enforce this section. However, the Court found that this did the plaintiffs no good, because their substantive arguments did not show any failing in Indiana's plan. The plaintiffs contended that the section required comprehensive studies prior to any change in the state's plan of reimbursement. Nothing in the language of the section or any implementing regulation requires a state to conduct studies in advance of every modification. It requires each state to produce a result, not to employ any particular methodology for getting there. In this sense, the section is distinguishable from the Boren Amendment, which required the state to adopt rules that the state finds, and makes assurances satisfactory to the secretary, are

reasonable and adequate to achieve identified objectives. In *Wilder*, it was concluded that a state could not make the necessary findings and assurances without conducting a study.

Blessing v. Freestone, 520 U.S. 329, 117 S.Ct. 1353, 137 L.Ed.2d 569 (1997) - Five Arizona mothers, whose children were eligible for state child support services under Title IV-D of the Social Security Act, filed a 42 U.S.C. §1983 suit against the petitioner, the Director of the State Child Support Agency, claiming that they properly applied for child support services and despite their best efforts to cooperate, the agency never took adequate steps to obtain child support payments for them. They attributed the omissions to staff shortages and other structural defects in the state's program. The systemic failures were alleged to violate their individual rights under the Act to have all mandated services delivered in substantial compliance with the Act and its implementing regulations. They sought an injunction and declaratory judgment. The 9th Circuit Court of Appeals found in favor of the mothers. The United States Supreme Court unanimously disagreed, holding that Title IV-D did not give individuals a federal right to force a state agency to substantially comply with that statute.

The Court of Appeals applied the *Wilder* analysis finding that needy families with children were the intended beneficiaries of the Act. It was found that the plaintiffs asserted interest is not vague or amorphous and that it is sufficiently concrete to be judicially enforceable because whether a state delivers the services required by the Act to the degree required by law is judicially ascertainable. The Court of Appeals found that the statute imposed binding obligations, because a state must satisfy each of the requirements spelled out in the Act in order to receive AFDC funding. The Court of Appeals concluded that suit could be maintained under §1983 in order to bring Arizona's child support enforcement program into substantial compliance with federal law. The Court of Appeals disagreed with the conclusion of the District Court that Congress had implicitly foreclosed an individual remedy under 1983 for violations of the Act. The majority found no provisions for judicial enforcement that might supplant the §1983 remedy. Instead, the law simply gave the Secretary administrative oversight powers that were virtually indiscernible from those the Court had found insufficient to displace §1983 liability in *Wright v. Roanoke Redevelopment and Housing Authority*, 479 U.S. 418, 107 S.Ct. 766 (1987).

The United States Supreme Court granted certiorari to resolve this agreement among the Courts of Appeal as to whether individuals may sue state officials under §1983 for violations of Title IV-D.

Employing a methodical analysis, which the Court determined had not occurred below, the Court found no federal right, arising from the statute. The Court left open the possibility that Title IV-D might give rise to some individually enforceable rights. The Secretary's oversight powers are not comprehensive enough to close the door on §1983 liability. The respondents' request for relief no more specific than a declaration that their "rights" were being violated and an injunction forcing Arizona's child support agency to "substantially comply" with all of the provisions of Title IV-D was not sufficient.

Rite Aid of Pennsylvania, Inc. v. Houstoun, 171 F.3d 842 (3rd Cir. 1999 – Pennsylvania opted to cover prescription drugs and related services in its state Medicaid plan. Rite Aid and other members of the Pennsylvania Pharmacists Association voluntarily participated as enrolled providers in the Pennsylvania Medical Assistance Program, pursuant to provider agreements executed with the Department. The agreements provide that the providers will be reimbursed for prescription drugs and related services in accordance with applicable federal and state laws and regulations. Among those laws is 42 U.S.C. §1396a(a)(30)(A). Regulations require that in the event of an amendment to the state plan, the state must consult with a medical care advisory committee which must have an opportunity for participation and policy development and program administration. The plan must be submitted for approval by HHS through HCFA. There is a requirement for public notice for changes in the methods and standards for setting payment rates for services before the effective date of the change. A period for public comment and criticism is to be afforded.

Before the October 1, 1995 rate revisions, the Department reimbursed pharmacies for the ingredient costs for brand name drugs at the average wholesale cost. For generic drugs, the formula followed the state maximum allowable costs guidelines. There was a dispensing fee of three dollars, fifty cents ($3.50) per prescription. Pennsylvania had good reason to revise these rates. For several years prior to 1994, HCFA had been advising the Department that its rates for reimbursement were high, given, among other reasons, changes in the drug marketplace. HCFA informed the department that it would not accept every wholesale price levels for estimated acquisition costs without a significant discount being applied, unless the department provided

documentation that the actual acquisition costs equaled the full average wholesale price. Also, at the end of 1994, a three year moratorium imposed by federal law, which prevented the department from amending its pharmacy reimbursement formulae was due to expire.

In September of 1994, the department proposed to modify pharmacy reimbursements by requiring pharmacies to charge the department the lowest rate it charged any other third-party payor, including private insurers. The proposal was forwarded to the pharmacy subcommittee of the Medical Care Advisory Committee and sent to the Governor's budget office, as a plan to save the state approximately twenty-one million, four hundred thousand dollars ($21,400,000.00) for the fiscal year 1995-1996. The Governor put it in the budget. The pharmacies criticized the proposed cuts. The department conducted a further review and evaluation and delayed the anticipated implementation date. The department chose a new reimbursement structure. The department learned that Pennsylvania was fifth in the nation for Medicaid program expenditures and that it was the only state surveyed that did not use federal upper limits as the cost limit for generic drugs. It was one of just four states using the full average wholesale price for brand name drugs. It had the highest rate of Medicaid payments for Region III states and the highest Medicaid expenditures of the top 10 drug expenditure states.

On August 8, 1995, the department submitted the amendment regulations to the Independent Regulatory Review Commission, which received comments during its review, and presented the department with a series of questions. The department published a notice on August 26, 1995, in the *Pennsylvania Bulletin* stating that the department will amend the reimbursement rates and providing a synopsis of the changes. The IRRC conducted a public meeting with representatives with the department, public and pharmacies present. Regulations were deemed approved by the IRRC on September 8, 1995 to take affect October 1, 1995. The Order Adopting the Regulations was published. December 29, 1995, the department sent the state plan amendment to HCFA for approval. HCFA approved it on May 7, 1996 with changes effective retroactively to October 1, 1995.

Rite Aid filed suit on March 27, 1997. The District Court granted Rite Aid's motion for summary judgment, finding that the department had violated §30(A) because it acted arbitrarily and capriciously procedurally in adopting the revisions. It enjoined the department from reimbursing pharmacies for drugs supplied to Medicaid recipients on or after October 1, 1998, in accordance with the rates and dispute. The Court found that the department did not comply with

its regulatory obligation to meet with the Medical Care Advisory Committee to discuss the regulations.

On appeal, Rite Aid did not challenge the substantive impact or results of the revised rates, as failing to comply with §30(A). They challenged the way in which the department set and promulgated the new rates.

The Court of Appeals found that §30(A) mandates only substantive compliance with its specified factors of efficiency, economy, quality of care and access. There is no procedural requirement on state agencies. The Courts of Appeals for the 8th and 9th Circuits have ruled that §30(A) requires that the state agency make some investigation or conduct a study.

The Court of Appeals for the 7th Circuit has held to the contrary that there is no such requirement, but rather that §30(A) requires simply that whatever change is adopted produced the substantive results demanded by the statute. *Methodist Hospitals, Inc. v. Sullivan*, 91 F.3d 1026, 1030 (7th Cir. 1996).

The Court of Appeals agreed with the 7th Circuit that §30(A) requires the state to achieve a certain result but does not impose any particular method or process for getting to that result. This section requires that the state "assure" certain outcomes, including efficiency, economy, etc., but it does not call explicitly for any particular findings. Thus, it is up to a state to determine how it will "assure" the outcome.

The District Court analogized §30(A) to the Boren Amendment, which dealt with reimbursement rates for institutional providers under Medicaid, but now has been repealed. §30(A) does not require a state to follow a specific procedure or demonstrate that it has reviewed each factor, contrary to the circumstances of the Boren Amendment.

The Court found that the department did not comply with its duty to consult adequately with the Medical Care Advisory Committee, but found that the violation could not support the injunction.

Evergreen Presbyterian Ministries, Inc. v. Hood, 235 F. 3d 908 (5th Cir. 2000) – The District Court granted a preliminary injunction in favor of the plaintiffs. The defendant Secretary of the Louisiana Department of Health and Hospitals appealed.

Due to a budgetary shortfall in Louisiana's Medicaid Program, and an executive order by Louisiana's Governor to achieve a savings in the state's general fund, the Louisiana Department of Health and Hospitals proposed a 7% across-the-board reduction of Medicaid reimbursement

rates paid to private healthcare providers and certain targeted cuts in Louisiana's Medicaid program. Providers objected and sued, seeking to prevent the reimbursement rate reduction from becoming effective. The focus of the suits became too sections of the Social Security Act, 42 U.S.C. §1396a(a)(13)(A) and §1396a(a)(30)(A).

In November of 1999, the Secretary was informed of a one hundred, fifty-three million dollar ($153,000,000.00) projected budget deficit within the Louisiana Department of Health and Hospitals Medicaid program for the 1999-2000 fiscal year. He reported the projected shortfall to the state's joint legislative committee on the budget. On December 7, the impending shortfall was compounded by an executive order from the Governor directing all executive branches to achieve a savings of approximately fifty million dollars ($50,000,000.00) in the state's general fund. The Secretary responded with various proposals including a 7% across-the-board reduction of reimbursements to private providers of services to Medicaid recipients. A spending reduction plan was devised to implement the reduction. This was presented to the joint legislative committee on the budget. Public notices in newspapers followed. The plaintiffs brought suit as their response to the proposed amendment. The District Court granted the plaintiffs' requested preliminary injunction, focusing its analysis on two sections of the Medicaid Act, 42 U.S.C. §1396a(a)(13)(A) and 42 U.S.C. §1396a(a)(30)(A), concluding that the plaintiffs provided sufficient evidence to support a substantial likelihood of a violation of each section.

On appeal, the Secretary did not contest the question of whether the plaintiffs had a right of action under 42 U.S.C. §1983.

§13(A) concerns a public process for determination of rights of payment under the plan for hospital services, nursing care facilities, and services of intermediate care facilities for the mentally retarded. The question was whether the Secretary had complied with the notice requirement. The Court of Appeals found that the 7% reduction language was sufficient to satisfy the first requirement of providing interested persons with "reasonable opportunity to review" the proposed rates. The Court found the notice of the proposed rates to be satisfactory. The combination of the reference to the existing methodology in the published notices, plus the announcement that the current rates would be reduced by 7% was sufficient to provide those interested with reasonable notice of a methodology underlying the proposed rates. The plaintiffs were provided with more than adequate notice and opportunity for review and comment. The

District Court abused its discretion in determining that the Secretary failed to comply with the procedures of §13(A).

The Court of Appeals found that the recipients had a right of action under §1983. However, the Court of Appeals differed with the District Court and held that the providers did not.

The Court of Appeals discussed the test established by the *Wilder* and *Blessing* decisions §13(A) followed in legislative history from the Boren Amendment. The *Wilder* decision construed the Boren Amendment as making providers intended beneficiaries of it and correspondingly affording them a federal right, not expressly or impliedly foreclosed.

As to the recipient plaintiffs, the court found that §30(A) protected them and their access to Medicaid care. The Court recognized that other Circuits had found that Congress intended §30(A) to benefit healthcare providers. However, those courts compared §30(A) to the Boren Amendment and had reasoned that a right of action existed in favor of healthcare providers, simply because §30(A) speaks in terms of payment to these providers. Reliance on the Boren Amendment is insufficient to resolve this issue. The *Blessing* and *Suter* decisions require a focus upon whether Congress intended to create an "individual entitlement" for each plaintiff. In contrast with the Boren Amendment, §30(A) does not create an "individual entitlement" for individual providers to a particular level of payment because it does not directly address those providers. Providers are not intended beneficiaries of §30(A).

As to the recipient plaintiffs, the court found that the equal access mandate of §30(A) is sufficiently definite to enforce and the section unambiguously imposes a binding obligation on the states.

Rocky Mountain Health Maintenance Organization, Inc. v. Colorado Department of Healthcare Policy and Financing, 2001 WL 1045537 (This opinion is not the final version and subject to revision upon final publication) – The trial court found in favor of Rocky Mountain Health Maintenance Organization, the HMO, in its breach of contract claim against the Colorado Department of Healthcare Policy and Financing. Rocky Mountain entered into three contracts with the Department to provide medical services to certain Medicaid recipients for the fiscal years 1997-1999.

Federal law requires those that choose to participate in the Medicaid program, to set rates on a actuarially sound basis. See §42 U.S.C. 1396b(m)(2000).

The specific contract provided for the calculation of the capitation rate on a seven step process. Rocky Mountain asserted that the Department had miscalculated the capitation rates for each year of the contracts and such constituted breach causing damages to Rocky Mountain. The facts were largely undisputed. The Department had a duty to calculate annually the specific dollar amounts of the capitation rates based on data from previous fiscal years. These calculations involve the analysis of massive amounts of data and took months to complete. As a result, the capitation rates were not finalized by the July 1 effective date of the contracts. The parties had contracted with each other since the 1970's. They had a understanding that the Department would voluntarily correct any rate errors that were later discovered. The parties had customarily and routinely corrected rate errors, prior to 1996. In 1996, the Department hired a new Director and the correcting stopped. The Department contended that Rocky Mountain lacked a remedy at law. The Department had unilaterally set the rates and Rocky Mountain lacked any meaningful input into the rate-setting process. The Department hired an actuarial firm to conduct a review of the rates and one actuary testified that he discovered at least fifteen (15) errors in the Department's rate calculations. There was other evidence of miscalculation.

The Trial Court found that the contracts required the Department to follow the seven step process and applicable state and federal law in setting capitation rates. Before the disputed period, the Department had corrected the rates when errors had been discovered in its calculations.

The Court of Appeals concluded that the Trial Court did not err in determining that the Department breached the plain language of the contracts that required it to follow the seven step process and relevant state and federal laws. It was not error to permit the testimony of the actuarial experts to show the miscalculation. It was not error to allow the testimony regarding the past practice of correction of rate mistakes.

Alexander v. Sandoval, 532 U.S. 275, 121 S.Ct. 1511, 149 L.Ed.2d 517 (2001) – This suit was brought against the Director of the Alabama Department of Public Safety, a recipient of federal financial assistance to enforce disparate-impact regulations promulgated under Title VI of the Civil Rights Act of 1964, at 42 U.S.C. §2000d et seq. Alabama amended its constitution in 1990 to declare English "the official language of the state of Alabama." The Department of Public Safety decided to administer state driver's license examinations only in English. A class action was brought in the United States District Court for the Middle District of Alabama to

enjoin the English-only policy, arguing that it violated the Department of Justice regulation, because it had the effect of subjecting non-English speakers to discrimination based on their national origin. The District Court agreed and enjoined the policy, ordering the Department to accommodate non-English speakers. The Eleventh Circuit Court of Appeals affirmed.

Private individuals may sue to enforce §601 of Title VI and obtain both injunctive relief and damages. §601 prohibits only intentional discrimination. Regulations promulgated under §602 of Title VI may validly proscribe activities that have a disparate impact on racial groups, even though such activities are permissible under §601. However, the Court held that neither as originally enacted nor as later amended does Title VI display an intent to create a freestanding private right of action to enforce regulations, promulgated under §602. No such right of action exists.

Barton v. Summers, 293 F.3d 944 (6th Cir. (Tenn.) 2002) – Medicaid recipients with tobacco-related illnesses brought a §1983 action against Tennessee and Kentucky, seeking injunctions forcing the states to turn over portions of tobacco settlement proceeds. The respective district court's dismissed the actions. The Court of Appeals found that the Eleventh Amendment barred the claims of the plaintiffs. This suit was not an exception to application of the Eleventh Amendment, as it was not a suit seeking injunctive relief for prospective and non-monetary purposes.

Beyond the Eleventh Amendment question, the Court noted that the 6th Circuit has only recognized a private right of action to enforce Medicaid Act provisions when the putative plaintiffs were very clearly the intended beneficiaries of the law in question.

Pennsylvania Pharmacists Association v. Houstoun, 283 F.3d. 531, (3rd Cir. 2002) – The Pennsylvania Pharmacist Association and others brought suit under 42 U.S.C. §1983 against Feather O. Houstoun, the Secretary of the Pennsylvania Department of Public Welfare, to challenge the reimbursement rates paid to pharmacies under Pennsylvania's Medicaid program. Violations of the Medicaid Act were claimed. The principal claim was based upon 42 U.S.C. §1396a(a)(30)(A)("§ 30(A)"). The District Court held that the plaintiffs could assert their §30(A) claim under §1983, but it granted summary judgment against them. The Court of Appeals held that the plaintiffs, as Medicaid providers, may not assert their claims under §1983.

In 1997, Pennsylvania began its Health Choices program, a mandatory managed care program operated in five counties in the southeastern part of the state, pursuant to an HCFA

waiver from certain provisions of the Medicaid Act. The Department contracted with four HMOs. Three of them administered pharmacy benefits through contracts with pharmacy benefits managers. The HMO and the pharmacy benefits manager set the rates at which pharmacies are reimbursed. The pharmacy benefits manager contracts directly with the participating pharmacies. The plaintiffs' principal claim was that the new payment rates violated §30(A).

In using the tests and language from the *Wilder*, *Blessing*, *Sandoval* and *Suter* decisions, the Court focused upon what standards might be found within §30(A). It found that pharmacies, as providers, were not the persons that Congress intended to benefit. The Court noted the sharp contrast between the language of §30(A) and that of the Boren Amendment, which was the frame of reference for the interpretation in the *Wilder* decision.

The majority of the Court was convinced that §30(A) is not intended to benefit providers and that therefore providers may not assert a §30(A) claim under §1983.

Westside Mothers v. Haveman, 289 F.3d. 852 (6th Cir. 2002) – This suit was filed under 42 U.S.C. §1983, alleging that the State of Michigan had failed to provide services required by the Medicaid program. The plaintiffs were advocacy and professional organizations and individuals. They contended that the Director of the Michigan Department of Community Health and the Deputy Directory of the Michigan Medical Services Administration did not provide the early and periodic screening, diagnosis and treatment services, mandated by the Medicaid Act and related laws. This suit was premised upon various statutes and regulations.

The District Court dismissed various parties at differing times. The District Court held that Medicaid was only a contract between a state and the federal government, that spending-power programs, such as Medicaid, were not the supreme law of the land, that the courts lack jurisdiction over the case because Michigan was the "real defendant and therefore possessed sovereign immunity against suit," that in this case *Ex parte Young* was unavailable to circumvent the state's sovereign immunity, and even if it were available, §1983 does not create a cause of action available to plaintiffs to enforce the provisions in question. The Court of Appeals reversed on all issues.

The Court used the analysis of the *Blessing* case to find a private right of action under §1983.

On the subject of standing for the two professional organizations, the Court looked to 42 U.S.C. §1396a(a)(30)(A) and the decision in *Wilder*. The Court found similar language in the Boren Amendment and §30(A) and stated that the statutes speak of the need to "assure the payments. . . are sufficient to enlist enough providers." The Court found that the members of the organizations have suffered an injury by not receiving compensation for medical services they are ethically compelled to provide. Accordingly, the Court found that the organizations met the requirements for associational standing.

SCOPE OF ANALYSIS

The undersigned has been appointed by the Commissioner for the Department of Commerce and Insurance to serve as a Special Deputy Liquidator, pursuant to T.C.A. §56-9-310(a)(1), to evaluate the three specifically referenced matters in litigation. The purpose of the Special Deputy Liquidator is to evaluate the litigation to determine, pursuant to T.C.A. §56-9-310(a)(14) whether to continue to prosecute the pending litigation in the name of TCCN or to abandon the pending litigation as unprofitable to TCCN.

The Commissioner, as Liquidator, submitted a recommendation of the process to be utilized by the Commissioner to determine the appropriate disposition of these matters in litigation. The Special Deputy Liquidator is to take the statutorily -prescribed the duties, pursuant to T.C.A. §56-9-310(a)(14) to make the determination regarding rather the litigation is profitable to pursue or should be abandoned. The sole consideration in forming the Commissioner's decision is economic: will continuation of the pending litigation, enhance the Commissioner's attempts to marshal TCCN's assets for the benefits of its creditors.

Generally, as a Liquidator of an insolvent insurance company, the Commissioner may "pursue any litigation that has the potential of increasing the assets of the company." 1 Couch on Insurance, Third Ed., §5.39. T.C.A. §56-9-310(a)(14) specifies that the continued litigation must be "profitable" to the litigation estate.

In performance of a similar fiduciary duty, trustees for federal bankruptcy cases filed under Chapter Seven of Title XÎ of the United States Code are admonished to abandon property, including litigation in process at the time that the bankruptcy litigation is instituted, "when the total amount to be realized would not result in a meaningful distribution to creditors or would

redound primarily to the benefit of the trustee and professionals." The Depar tment of Justice Handbook for Chapter 7 Trustees, March 1, 2001, at page 8-3. Further, Chapter 7 Trustees are advised to demonstrate the basis for the decision to abandon an asset which may include factors such as whether: ". . . the costs of recovering and/or liquidating the asset are estimated to exceed its value to the estate. . ." Id. at p.8-4.

FINDINGS AND CONCLUSIONS

Accordingly, within the scope for the evaluation and after a review of the documents and circumstances relating to the Pending Litigation, the Special Deputy Liquidator offers the following findings and conclusions:

1. TCCN v. State of Tennessee, Davidson County Chancery Court, Case No. 01-1791-II.

This case was filed as a claim for damages or breach of contract before the Claims Commission of the State of Tennessee. The case was transferred to the Davidson County Chancery Court.

Pursuant to the provisions of T.C.A. §9-8-307, the Tennessee Claims Commission may hear actions for breach of a written contract between the claimant and the State, which was executed by one or more state officers or employees with authority to execute the contract. T.C.A. §9-8-307(a)(1)(L). Claims against the State filed pursuant to subsection (a) shall operate as a waiver of any cause of action, based on the same act or omission, which the claimant has against any state officer or employee. T.C.A. §9-8-307(b). The State will be liable for actual damages only. T.C.A. §9-8-307(b). The provisions for the Tennessee Claims Commission are not intended to be construed as a waiver of the immunity of the State of Tennessee from suit in federal courts guaranteed by the Eleventh Amendment to the Constitution of the United States. T.C.A. §9-8-307(f). No language is intended to be construed to abridge the common law immunities of state officials and employees. T.C.A. §9-8-307(g).

This claim is stated as a claim for breach of contract or contracts. TCCN contended that other TennCare managed care organizations and healthcare providers should be permitted to intervene. No interventions have occurred. However, the point is well taken, in that the contractual provisions were universal across the HMO TennCare landscape. As the affidavits of

the state officials established through the history of TennCare, the contracts and the amendments were universally applied. A change for one HMO became the change for all. As financial pressures had ebbed and flowed, capitation rate modifications were made, some retroactively, in order to attempt to deal with evolving circumstances.

While TCCN contended that the contracts themselves were breached, the gravamen of TCCN's complaint is that the TennCare capitation rate process, whether for TCCN, John Deere or BlueCross/BlueShield, was not correctively formulated. It is the focus upon federal statutory and regulatory premises that lies at the heart of TCCN's claim in this particular action. These matters are not the mistaken calculation scenario developed within the Colorado case, cited above. See *Rocky Mountain Health Maintenance Organization, Inc., discussed above.*

The TennCare program began with a State commissioned analysis by KPMG Peat Marwick, which concluded by letter of June 3, 1993, that, "Overall, our review found the TennCare benefit package to be reasonable and the methodology utilized in the calculation of the adjusted cost per eligible month to be actuarially sound." The State continued through the life of the TennCare Program to commission additional studies and apply the findings for the benefit of the program recipients, participating through MCO's.

The likelihood of successful recovery in this action is minimal at best. TCCN, then known as Tennessee Managed Care Network, entered the TennCare program at the inception with Medicaid HMO experience on a smaller scale. The TennCare program offered it the opportunity to expand its scope of member service multifold. Perhaps, it successfully marketed itself into a hole. Its refusal to leave the program as it could have done contractually, coupled with its continuing to contract through a series of agreements, creates strong issues of waiver and estoppel.

As a matter of contract and procedure, it appears that TCCN failed to provide written notice of its claims as a condition to recovery as required at T.C.A. §9-8-402 and within section 4-18 of the Contractor Risk Agreement.

Accordingly, this suit is of no appreciable value to the Liquidation and may reasonably be abandoned.

2. **TCCN v. Neel**, United States District Court for the Middle District of Tennessee, Case No. 3:00-1226.

In this suit, TCCN was seeking prospective injunctive relief in the form of a recalculation of appropriate capitation rates. The suit was filed on December 13, 2000, the day after the breach of contract claim was filed with the claims commission. The suit was premised upon 42 U.S.C. §1983 and further upon violations of the Medicaid Act at 42 U.S.C. §1396a(a)(30)(A) and 42 U.S.C. §1396b(m)(2)(A)(iii).

The current status of this case is that summary judgment was granted to the state defendants and the case is before the 6th Circuit Court of Appeals.

The District Court found no HMO entitlement under these provisions of the Medicaid Act. As to §1396a(a)(30)(A), it was intended to benefit Medicaid recipients. There is a split of authority as to whether providers are intended beneficiaries. The District Court found no evidence that Congress intended to extend beneficiary status to managed care organizations. Accordingly, there is no private right of action to be enforced.

Regarding §1936b(m)(2)(A)(iii), and the implementing regulations, the established restrictions are on payments to managed care organizations that must be met in order for federal funds to be available to support state payments for managed care. The language is mandatory upon states wishing to receive federal financial participation. The statute was not intended to benefit managed care organizations. No private right of action for the plaintiff is created.

The District Court noted the split of authority in the Circuits regarding provider private rights of action. While it might be instructive to restate the development of this area of the law from *Wilder* through *Westside Mothers*, and to attempt to determine who might be a better student and interpreter of statutory language and Congressional intent, such an exercise is not necessary for an analysis of the profitability of this particular suit. Before leaving the point though, the District Court is likely correct that a fair reading of these provisions of the Medicaid Act does not illuminate an intended benefit for an HMO or obligation for its benefit. §1396b(m)(2)(A)(iii) speaks directly of the benefit of individuals eligible for benefits. §1396a(a)(30)(A) permits some inferential consequential benefit, but no intentional and obligatory reference or inclusion.

This suit is moot. TCCN is not a functioning HMO. Its survives in liquidation on only legally cognizable life support. It has no need for future injunctive relief by way of calculation or amendment of capitation rate methodologies. If by the time a controversy reaches the appellate court, questions presented have been deprived of practical significance and have

become academic and abstract in character, the appeal should be dismissed as moot. *Perry v. Banks*, 521 S.W.2d. 549, 550 (Tenn. 1975); *LaRouche v. Carowell*, 709 S.W.2d 585, 587 (Tenn. App. 1985). This is particularly true when the relief sought is injunctive. "Where it appears the act to be enjoined has been consummated, an action for an injunction presents only a moot question and will be dismissed." *Badgett v. Broome*, 219 Tenn. 264, 268, 409 S.W.2d 354, 356 (1966), *State ex. rel. Adventist Healthcare Systems/Sunbelt Healthcare Corporation v. Nashville Memorial Hospital, Inc.*, 914 S.W.2d 903, 907 (Tenn.Ct. App. 1995).

Any attempt by the Liquidator at this time to convert a claim for injunction to one for damages, would invoke Eleventh Amendment problems, that could not be remedied by arguing the exception to the Eleventh Amendment found in *Ex parte Young*, 209 U.S. 123, 52 L.Ed. 714, 28 S.Ct. 441 (1908). This exception permitted a suit seeking prospective but not compensatory or other retrospective relief, to be brought against state officials in federal court.

Accordingly, this suit, attempting to seek injunctive relief for capitation rate calculation and other related issues since December 13, 2000, is of no appreciable value to the Liquidation and may reasonably be abandoned.

3. **TCCN v. Neel**, United States District Court for the Middle District of Tennessee, Case No. 3:01-0126.

This suit was filed January 3, 2001, in the Chancery Court for Davidson County, Tennessee. It is now pending in the United States District Court for the Middle District of Tennessee at Nashville. Limited discovery has occurred. The defendants have moved for summary judgment. The Motion is supported by elaborate affidavits of Manny Martins, Deputy Commissioner, TennCare Division of Department of Commerce and Insurance; John F. Tighe, Deputy Commissioner of the Tennessee Department of Finance and Administration for the Office of Health Services; and Patricia L. Newton, Assistant Commissioner, TennCare Division of Department of Commerce and Insurance.

The verified complaint was filed by TCCN seeking declaratory judgment and a preliminary and permanent injunction. TCCN contended that at the time of the filing of the complaint, the defendants were violating federal and state laws governing the operation of the TennCare program and its civil rights, protected under federal and state law. TCCN seeks a preliminary and permanent injunction against the defendants to stop the continuing violation of those laws and rights.

TCCN alleges that it is a not-for-profit health maintenance organization that is an African-American managed and operated entity. It avers that it is recognized as a minority business enterprise. It holds a managed care risk contract in the TennCare program.

The complaint includes a statement regarding the TennCare program and some of its history. It is alleged that TennCare has been mismanaged and grossly underfunded for most of its existence since 1994. However, in 1998, 1999 and continuing into the year 2000, it is alleged that the TennCare defendants engaged in a serious of venal actions targeting TCCN as an African-American MCO with the intent to impair its financial ability to comply with state laws, to interfere with its business operations, to damage its business reputation, and, ultimately, to render it not qualified to hold a TennCare contract. It is alleged that none of the non- African-American MCOs were subjected to such action or were the victims of the disparate impact of those actions. The complaint discusses actions and circumstances creating financial disruption for TCCN dating back to 1995. TCCN alleges that the TennCare defendants employed a strategy to disqualify TCCN. Another means of conspiracy was associated with problems with prompt payment dating back to December of 1999, when TCCN and other businesses around the world were coming to grips with Y2K issues. TCCN alleges that various regulatory actions beginning in June of 1999 were pretextural smoke screens behind which the insurance department defendants attempted to damage it. TCCN avers that the TennCare defendants unlawfully manipulated the process by which Medicaid beneficiaries are enrolled in MCOs, in order to divert a significant percentage of the adverse selection population to TCCN, all for the purpose of increasing the financial risk of TCCN and to make it more difficult for it to meet statutory net worth requirements.

Count I of the Complaint incorporates allegations and theories, borrowed from one of TCCN's other pending suits. This count focuses upon the Medicaid Act Provisions at 42 U.S.C §1396a(a)30(A) and avers that it is an intended beneficiary of this provision, which is referred to as the Equal Access Clause. TCCN claims a violation of 42 U.S.C §1983. It seeks specific relief in three forms: a declaration that the TennCare defendants violated these two statutes; an injunction requiring the TennCare defendants to comply with 42 U.S.C §1396 and to stop manipulating the reimbursement rates to harm TCCN and disqualify it; and for attorneys' fees and costs.

Count II is premised upon 42 U.S.C. §1981 et seq., which protects persons from discrimination on the basis of race in making and enforcing contracts, in the application of laws, and in proceedings affecting contracts. Although TCCN is a non-profit corporation, it alleges that it is an African-American owned, as well as managed, MCO. It alleges that it has been purposefully and intentionally discriminated against and treated differently on the basis of race. It seeks a declaration that the TennCare defendants have violated this specific statute. It seeks an injunction to stop that and to enjoin the institution of a rehabilitation action against it. It seeks an injunction to require the TennCare defendants to extend to it the same contract rights and benefits and to enforce equally as to TCCN and white-owned or managed MCOs. It seeks attorneys' fees and costs.

Count III is premised upon 42 U.S.C §§2000d et seq. ("Title VI"). TCCN alleges that the TennCare defendants have been and continue to violate TCCN's rights under this statute by intentionally discriminating against it on account of race and also through actions that have a disparate adverse impact on it. Title VI provides that no person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. TCCN requests a declaration that the TennCare defendants violated this statute. TCCN seeks an injunction to stop the violation and to require the TennCare defendants to cease their intentionally discriminatory conduct. TCCN requests an injunction to implement non-discriminatory methodologies and policies that do not have a disparate effect on TCCN and other African-American owned or managed MCOs. It seeks attorneys' fees and costs.

Count IV is premised upon allegations of the deprivation of rights secured by the 5th and 14th Amendments of the United States Constitution and Article I, §21 of the Constitution of the State of Tennessee. TCCN requests a declaration that the actions of the defendants violated these provisions. TCCN seeks an injunction from continuing violation. TCCN seeks attorneys' fees and costs.

In its Federal Rule of Civil Procedure 26(a)(1) initial disclosures, TCCN responded to subpart (C) for a computation of damages, that this was not applicable. "TCCN seeks equitable relief. Such relief, if granted, may require one or more of the Defendants, on behalf of the State of Tennessee, to make additional payment to TCCN as a provider in the TennCare Program. The form and amount of such payment will depend upon the specific findings and Order of the Court

at the conclusion of this action. Since such payment would not be 'damages' and even if within the scope of damages as the word is used in Rule 26(a)(1)(c) is not presently calculable, no computation is provided herein."

As to Count I, premised upon §1983 and the provisions of 42 U.S.C. §1396a, the analysis is as referenced above in the discussion regarding the other federal case, which was dismissed on motion.

All four of the counts in the Complaint seek declaratory relief and injunctive relief as noted above. With TCCN being in liquidation and out of business, such declaratory and injunctive relief is without practical consequence and accordingly is of no value to the Liquidator. Those matters are moot.

Were the claims within Counts II and III to survive, the extensive affidavits filed in support of the defendants' motion for summary judgment establish a factual background that would make it exceedingly difficult to establish sufficient proof of intentional discrimination.

As to allegations of intentional discrimination and disparate impact, involving rights under 42 U.S.C. §2000d, Title VI regulations do not create a private right of action. *Alexander v. Sandoval*, 532 U.S.275,121S.CT.1511, 1523, 149L.ED.2d517(2001).

With respect to the claim contained within Count IV, the Complaint does not allege any facts that would support a violation of federal or state due process claims.

The state defendants included within their answer various affirmative defenses, including the contention that some or all of the events alleged in TCCN's Complaint are barred by the applicable statutes of limitation, the Eleventh Amendment, and/or the doctrine of sovereign immunity. TCCN avoided most of the impact of these defenses by seeking declaratory and injunctive relief only. Had state law claims been a part of this action, they might arguably survive Eleventh Amendment immunity, by virtue of the removal of the cause to federal court, and to the extent that the State had explicitly waived immunity from state court proceedings. See *Lapides v. Board of Regents of the University System of Georgia*, 122 S. Ct. 1640; 152 L. Ed. 2d 806, 2002 U.S. Lexis 3220 (2002).

Another affirmative defense that was asserted was the lack of standing. TCCN evolved to the point where, by the time of the filing of this suit, it was a not-for-profit corporation with a TennCare contract, related provider agreements, and one employee. The substantial work and management activities were done by other persons and entities not before the Court.

The decision not to seek and request a specific claim for monetary damages per §2000d, is considered to have been a thoughtful decision by TCCN at the time this suit was filed. As to the third suit, and with the plethora of allegations and theories, despite the opportunity to argue abrogation, difficulty proving actual damages from prior alleged conduct, was likely too great.

Accordingly, this suit is of no appreciable value to the Liquidation and may reasonably be abandoned.

The cost of pursuing the Pending Litigation to a fully litigated conclusion would be quite substantial. None of the suits have progressed beyond the early written discovery stage. The initial disclosures by TCCN listed over thirty potential witnesses with knowledge of discoverable information. It would be anticipated that proceeding with the actions on behalf of the Liquidation would involve substantial actuarial analysis and involvement, which would require the work and testimony of various expert witnesses. There is no reason to believe that a vigorous defense would not be waged. It would be reasonable to assume that as many as two to three attorneys would be needed to represent the Liquidator, if the suits were to go forward. The legal and related costs to the Liquidation would easily exceed $250,000.00, and could potentially exceed $500,000.00.

The Special Deputy Liquidator respectfully recommends that the three TCCN causes of action, described and analyzed above, be abandoned.

Respectfully submitted,

Howard H. Vogel with permission by Paula Flowers

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CERTIFICATE OF SERVICE

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